STATE OF SOUTH CAROLINA	)	
	)	BEFORE THE CHIEF PROCUREMENT OFFICER
COUNTY OF RICHLAND	)	
	)	**DECISION**
In the Matter of Protest of:	)	
	)	CASE No's 2010 – 150, 151, 152, 153
Logisticare Solutions	)	
Medical Transportation Management	)	
Adrian Novit	)	
Sonny Williams	)	
	)	
Materials Management Office	)	POSTING DATE: February 9, 2011
RFP No. 5400002201	)	
Non-Emergency Medical Transportation	)	MAILING DATE: February 9, 2011
Department of Health & Human Services	)	

This matter is before the Chief Procurement Officer (CPO) pursuant to letters of protest from Logisticare Solutions, LLC (Logisticare), Medical Transportation Management (MTM), Adrian Novit, and Sonny Williams. The Materials Management Office (MMO), on behalf of the Department of Health and Human Services (DHHS), issued a request for proposals (RFP) in order to acquire statewide non-emergency medical transportation services (NEMT) for eligible Medicaid recipients.

The state's Non-Emergency Medical Transportation Program provides for non-emergency transportation of eligible Medicaid members to medical care or services which are covered under the Medicaid Program. Federal requirements regarding this program appear in transportation services are described in 42 CFR section 440.170(a)(4).

The RFP sought proposals to award separate contracts for each of three (3) regions within the state. Each contract would engage a qualified broker responsible for administering the core components of the DHHS NEMT Program.

On December 3, 2010, the procurement officer for this solicitation, Mr. Daniel Covey, CPPB, posted the following notices regarding the state's an intent to award contracts. Both contracts have a maximum contract period of December 14, 2010 to December 13, 2015.

Region 1
Logisticare
Total Potential Value: $72,607,425

Regions 2 and 3
AMR
Total Potential Value: $162,077,477

The following protest letters were submitted:

Protestant	Date Received	Regions Protested
MTM	12/10/2010	1, 2, 3
MTM	12/20/2010 (amending 12/10 letter)	1, 2, 3
Logisticare	12/13/2010	2, 3
Logisticare	12/17/2010 (amending 12/13 letter)	2, 3
Sonny Williams	12/10/2010	Unspecified / presumably 3
Adrian Novit	12/14/2010	Unspecified / Presumably 3

In order to resolve the matter, the CPO conducted a hearing January 24 and 25, 2011. Appearing before the CPO were MTM, represented by E. Wade Mullins, III, Esq.; Logisticare, represented by John E. Schmidt, III, and Melissa J. Copeland, Esquires; Sonny Williams, representing himself; AMR, represented by M. Elizabeth Crum, Esq.; DHHS, represented by Deirdra Singleton and Vicki Johnson, Esquires; and MMO, represented by John Stevens, State Procurement Officer. Adrian Novit did not attend the hearing.

NATURE OF PROTEST

The letters of protest are attached and incorporated herein by reference.

FINDINGS OF FACT

The following dates are relevant to the protest:

1. On September 9, 2010, MMO issued the RFP. (Ex. 1)

2. On September 20, 2010, MMO and DHHS conducted a pre-proposal conference.

3. On October 3, 2010, MMO issued Amendment #1. (Ex. 2)

3. On October 11, 2010, MMO issued Amendment #2. (Ex. 3)

4. On October 25, 2010, MMO opened the proposals received.

5. On December 3, 2010, MMO posted its intent to award.

PROTEST ISSUES

Given the number of allegations, the number of letters, and the overlap in issues, the CPO provides the following summary of the protest issues and identifies each with a number. Except for the protests submitted by Mr. Williams and Ms. Novit, the CPO will reference the issues of protest by the numbers assigned below.

By letter dated December 10, 2010, MTM raised the following issues of protest regarding the proposed awards to Logisticare for Region 1 and AMR for Regions 2 and 3.

1. **Pricing Mechanism.** The fixed, flat rate pricing mechanism of the solicitation shifts all NEMT program risks to the bidders. (MTM 12/10/2010 letter, Item 1, a.). The flat rate requirement without an actuarial study is a violation of 42 CFR 438.6(c)(2) and due process under the United States Constitution (MTM 12/10/2010 letter, Item 1, a, iii and iv).

2. **Actuarially Un-Sound Pricing.** The Deficit Reduction Act of 2005 and Regulations promulgated by the Centers For Medicare and Medicaid Services (CMS) require that risk based contracts be actuarially sound with respect to pricing (MTM 12/10/2010 letter, Item 1, a, i). The

State failed to commission an actuarial study in order to determine actuarially sound pricing parameters in violation of the Deficit Reduction Act and CMS regulations in violation of 42 CFR 438.6(c)(2). (MTM 12/10/2010 letter, Item 1, a, ii.) The State has not certified AMR's bid as actuarially sound. (MTM 12/10/2010 letter, Item 1, a, v.) The "lowball" pricing offered by Logisticare for Region 1 and AMR for regions 2 and 3 were not actuarially sound (MTM 12/10/2010 letter, Item 1, a, ii).

3. **Evaluation**. The evaluation and scoring of the proposals by Mike Benecke, David Giesen, and Sheila Platts was arbitrary and capricious. (MTM 12/10/2010 letter, Item 2.) As noted below, this issue was withdrawn at the hearing.

4. **Responsibility / Bad History**. AMR was not a responsible bidders as it has been sued twice in Texas for fraudulent kickbacks and false claims and the reported settlement per a newspaper article by the Houston Chronicle, a State of Texas audit of AMR dated October 30, 2007, and an article by the Spokane, Washington, "The Spokesman-Review dated December 3, 2010, cause suspicion of AMR's responsibility. (MTM 12/10/2010 letter, Item 3.)

5. **Responsibility / Not Accredited**. AMR is not accredited by URAC or NCQA, as required by Section 2.3.2 of the RFP. (MTM 12/10/2010 letter, Item 4.) As noted below, this issue was withdrawn at the hearing.

6. **Contract Service Implementation**. AMR is already committed to commence NEMT services implementation in Nebraska on the same day (MTM 12/10/2010 letter, Item 5). As noted below, this issue was withdrawn at the hearing.

By letter dated December 20, 2010, MTM raised additional issues of protest regarding the proposed awards to Logisticare for Region 1 and AMR for Regions 2 and 3. By letters dated

December 13, 2010 and December 17, 2010, Logisticare, which is protesting the award to AMR for Regions 2 and 3, raised the same issues.

7. **Post-Opening / Pre-Award Changes to Contract Scope**. On a December 14, 2010, DHHS issued a Medicaid Bulletin that announced significant changes to the South Carolina Medicaid Program by drastically reducing optional Medicaid services. These changes occurred after submission and opening of proposals, but prior to award. The protestants argue that those changes could cause the state to pay too much for NEMT. (MTM December 20, 2010 letter, Item 1; Logisticare 12/17/2010 letter, Item 1.)

8. **Pricing Information in Technical Proposal / Alteration of Proposals**. The protestants argue that AMR improperly included pricing information in its technical proposal in violation of the RFP, that Mr. Covey improperly modified AMR's technical proposal by removing AMR's pricing information, and, that with the pricing removed, AMR failed to provide any response. (MTM 12/20/2010 letter, Item 2 and the Logisticare 12/17/2010 letter, Item 2.)

9. **Misrepresentations - Postcard**. The protestants allege that AMR's proposal contains material misrepresentations that created the opportunity for improper influence over the evaluation of the proposals in that AMR in the form of a "sample postcard" falsely claims that it had won a NEMT contract by the State of Wisconsin, which it did not. (MTM 12/20/2010 letter, Item 2 and the Logisticare 12/17/2010 letter, Item 2.)

10. **Misrepresentation – Trip Software**. The protestants allege that AMR misrepresented the capability of its trip software and that the software for trip scheduling is unreliable for large transportation programs. (MTM 12/20/2010 letter, Item 2 and the Logisticare 12/17/2010 letter, Item 2.)

On December 10, 2010, Sonny Williams filed a protest alleging that Logisticare's loss of his region and the resulting closing of a call center in Mullins, SC would cause economic hardship due to the call center being moved to Columbia.

On December 14, 2010, Adrian Novit filed a protest alleging distress over Logisticare losing her region and disrupting transportation of Medicaid members.

WITHDRAWAL OF PROTESTS

During the hearing, MTM withdrew the following issues of protest:

#3 Evaluation
#5 Responsibility / Not Accredited
#6 Contract Service Implementation

In addition to those brought by Mr. Williams and Ms. Novit, the following protest issues remain:

#1 Pricing Mechanism
#2 Actuarially Un-Sound Pricing
#4 Responsibility / Bad History
#7 Post-Opening / Pre-Award Changes to Contract Scope
#8 Pricing Information in Technical Proposal / Alteration of Proposals
#9 Misrepresentations – Postcard
#10 Misrepresentation – Trip Software.

MOTIONS TO DISMISS

AMR offered several motions asking that the CPO dismiss certain protest issues raised by the parties.

I. AMR moves to dismiss the protests of Adrian Novit and Sonny Williams for lack of standing.

The CPO agrees. Section 11-35-4210 authorizes "[a]ny actual bidder, offeror, contractor,

or subcontractor who is aggrieved in connection with the intended award or award of a contract" to protest the proposed award to a chief procurement officer. Consistent with this provision of law, the South Carolina Procurement Review Panel (Panel) has repeatedly held that only an actual offeror has standing to protest an award or intended award. See, e.g., Protest of Winyah Dispensary, Inc., Case No. 1994-18; Protest of Smith & Jones Distrib. Co., Case No. 1994-5; Protest of Eastern Data, Inc., Case No. 1993-9; Protest of Laurens Co. Serv. Council for Senior Citizens, Case No. 1990-18; Protest of Quantum Res., Case No. 1990-17; see also Protest of Unknown Person (alias Jim Jones) vs. S.C. State Univ., Case No. 2007-5.

As neither Novit nor Williams submitted proposals, they lack standing to protest. Accordingly, their protests are dismissed as a matter of law.[1]

II. AMR moves to dismiss as untimely those matters that could have been raised as a protest of the solicitation.

The Code provides two opportunities to protest. One opportunity regards the right to protest any portion of a solicitation that aggrieves a prospective offeror. S.C. Code Ann. § 11-35-4210(1)(a). The other opportunity regards the right to protest an actual or intended award. S.C. Code Ann. § 11-35-4210(1)(b). In order to provide the state an opportunity to cure any defects prior to opening and award, the statute provides that "a matter that could have been raised . . . as a protest of the solicitation may not be raised as a protest of the award or intended award of a contract." S.C. Code Ann. § 11-35-4210(1)(b). In other words, for complaints directed to the

[1] The protest of Adrian Novit is also dismissed on the basis that it was untimely filed. Section 11-35- 4210 requires that a protest be received by the CPO within ten days of the date notification of award is posted. In this case, the award was posted on December 3, 2010. Therefore, any initial protest must have been received by the CPO by December 13, 2010. Novit's email was sent to Daniel Covey on December 14, 2010, thereby missing the December 13, 2010 statutory deadline.

solicitation, a prospective vendor cannot wait until it loses the contract to complain. See Protest of the Computer Group, Case No. 1996-6.

AMR argues that the following issues should be dismissed because they could have been raised as a protest of the solicitation dated September 9, 2010 or as a protest of Amendment No. 1 dated October 3, 2010

#1 Pricing Mechanism
#2 Actuarially Un-Sound Pricing

The allegations regarding these two issues include the following:

a. Medicaid population eligibility is so volatile that fixed, flat rate pricing where the broker assumes all risk of increases in the number of eligible beneficiaries is unconscionable, resulting in pure speculation by all bidders, and not consistent with commercially sound business practices, nor with federal laws and CMS regulation requiring actuarial sound pricing of federal government participation contracts. (MTM 12/10/2010 letter p. 1, ¶(1)(a).)

b. The failure by the State of South Carolina in not having obtained an actuarial study of the proposed contract for Medicaid NEMT program for this RFP constitutes a violation of the Deficit Reduction Act and CMS regulations. (MTM 12/10/2010 letter, p. 2, ¶(1)(a)(ii).)

c. A risk based, fixed, flat rate 3-5 year service contract entices speculative bidding without actuarially sound pricing parameters, and constitutes a denial of due process and equal protection of the law to MTM, in violation of the 5th and 14th amendments to the U.S. Constitution. (MTM 12/10/2010 letter, p. 2, ¶(1)(a)(iii).)

d. Pursuant to 42 CFR 438.6(c)(4), "[t]he State must provide ... actuarial certification of the capitation rates." (MTM's 12/10/2010 letter p. 3, ¶(1)(a)(iv).)

e. MTM submits that the State does not have a current actuarial certification as to the costs of its Medicaid NEMT services program. (MTM's 12/10/2010 letter p. 3, ¶(1)(a)(v).)

The matters protested with these allegations were raised in the solicitation. The RFP expressly requires fixed price offers. (See Page 103, §VII.A.) The RFP announces that the state would conduct an outside actuarial review, but only of fuel prices; RFP Amendment # 1, with

answer to Vendor No. 5, question 6, p. 17, addressed the actuarial evaluation of fuel prices only. Further, the RFP, in answer to Vendor No. 6, question 11, pp. 19-20, stated that "SCDHHS does not anticipate an annual outside actuarial review." The RFP's answer to Vendor question 21, p. 22 read, "SCDHHS does not anticipate an annual outside actuarial review." (See Exhibit 1, Solicitation p. 103 and Exhibit 4, Amendment 1, pages 17, 19, 20, and 22.) Clearly, prospective offerors were on notice of each of these issues. Accordingly, MTM was required to raise these grounds of protest with 15 days of the solicitation, in other words not later than September 24, 2010, or within 15 days of Amendment 1, no later than October 18, 2010. Having failed to submit a timely protest of the solicitation, MTM's protest regarding pricing, protest issue #1, is dismissed as untimely.

In addition to being untimely, MTM's allegations based on 42 CFR 438.6(c)(4) are dismissed because they fail to state a claim upon which relief can be granted. In order to state a claim, a protest must identify some defect, some violation of the law. Alleging a violation of this regulation fails to state a claim because 42 CFR 438.6(c)(4) is not relevant to this type of contract. Specifically the scope of part 438 is as follows:

> This part sets forth requirements, prohibitions, and procedures for the provision of Medicaid services through MCOs, PIHPs, PAHPs, and PCCMs. Requirements vary depending on the type of entity and on the authority under which the State contracts with the entity. Provisions that apply only when the contract is under a mandatory managed care program authorized by section 1932(a)(1)(A) of the Act are identified as such.

42 CFR 438.1(b). This procurement does not involve the provision of Medicaid services through a Managed Care Organizations (MCO), Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP), or Primary Care Case Management (PCCM). Rather, as stated

clearly in the RFP, the federal requirements related to this procurement are described in 42 CFR §440.170(a)(4). (See RFP § 1.1, p. 20.)

Regulation 440.170(a)(4) allows the State to "provide for the establishment of a non-emergency medical transportation brokerage program in order to more cost-effectively provide non-emergency medical transportation services for individuals eligible for medical assistance under the State plan who need access to medical care or services, and have no other means of transportation." Entities providing non-emergency medical transportation under contract are required to meet the following requirements:

> (A) Is selected through a competitive bidding process that is consistent with 45 CFR 92.36(b) through (i) and is based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs.
> (B) Has oversight procedures to monitor beneficiary access and complaints and ensure that transportation is timely and that transport personnel are licensed, qualified, competent, and courteous.
> (C) Is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services.
> (D) Is subject to a written contract that imposes the requirements related to prohibitions on referrals and conflicts of interest described at § 440.170(a)(4)(ii), and provides for the broker to be liable for the full cost of services resulting from a prohibited referral or subcontract.

42 CFR §440.170(a)(4)(i). There is absolutely no reference to the requirements of § 438 in the CFR Section relevant to this procurement.

MOTION FOR DIRECTED VERDICT

At the outset of the hearing, the following issues of protest were, as noted above, dismissed as untimely:

#1 Pricing Mechanism
#2 Actuarially Un-Sound Pricing

Regarding the second of these two protest issues, the gravamen of MTM's allegations is that the selected offeror's price should have been subjected to an actuarial analysis. Taken out of context, one might argue that allegations regarding "predatory, commercially unreasonable pricing in an attempt to 'buy' a State NEMT contract" form a distinct and independent issue of protest. Out of an abundance of caution, the CPO – despite having dismissed the second issue of protest as untimely – allowed MTM an opportunity to submit evidence regarding its allegations of unreasonable pricing and to explain the legal basis for this claim, i.e., to identify the law or rule violated.

For two days, MTM argued, but never offered any proof, that AMR's bid price is unreasonable. Likewise, no legal basis for this allegation was offered. As MTM rested its case, AMR moved for directed verdict, which the CPO granted. MTM failed in its burden of proof that the price proposals of AMR and Logisticare were unreasonable is granted.

CONCLUSIONS OF LAW

The remaining protest issues are as follows:

#4	Responsibility / Bad History
#7	Post-Opening / Pre-Award Changes to Contract Scope
#8	Pricing Information in Technical Proposal / Alteration of Proposals
#9	Misrepresentations – Postcard

These will be addressed below.

#4 Responsibility / Bad History

MTM alleged AMR was sued twice in Texas for fraudulent kickbacks and false claims and the reported settlement cited in a newspaper article by the Houston Chronicle, a State of Texas audit of AMR dated October 30, 2007, and an article by the Spokane, Washington, "The

Spokesman-Review dated December 3, 2010, cause suspicion of AMR's responsibility. (12/10/2010 letter, Item 3.) They argue that AMR's failure to report this information in its proposal violated a requirement that offerors were to "Provide a list of failed projects, suspensions, debarments, and significant litigation." (Ex. 1, p. 99, Qualifications, additional Information.) Further, they note the response in Amendment #1 to a question which reads, in part, as follows: "Many proposers do not fully disclose negative information which would impact their qualifications and/or evaluation of their qualifications. Based on this, we would like to request that the RFP be amended to require proposers to fully disclose certain serious negative contract problems, for themselves as well as their principles and affiliates, at least for contracts or potential contracts in the last seven years." The question continues to list seven examples. In response, Amendment #1 states: "Offerors are required to submit the information requested in this solicitation to evaluate their qualifications." (Ex. 2, pp. 13 and 14, Question and Answer 39.)

AMR responded that the lawsuits referenced in the Justice Department press release were not filed against ARM; that they were old - filed in 2000 and 2001 - outside of any reasonable reporting period.

The only evidence submitted was a Department of Justice press release dated October 5, 2006. (Ex. 17.) No actual newspaper articles were submitted to prove the existence of the newspaper articles alleged in the protest letter.

In this allegation, MTM and Logisticare question AMR's responsibility. The appropriate analysis of this allegation is whether Mr. Covey's determination of AMR's responsibility was arbitrary, capricious, contrary to law or clearly erroneous. Mr. Covey testified that he ran a Dunn & Bradstreet report of AMR in his determination of responsibility of AMR. That report of AMR indicates "0" suits. (Ex. 18, pp. 2, 8, and 26)

The CPO finds this allegation to be interesting, but not compelling evidence that Mr. Covey's determination was arbitrary. The CPO agrees with AMR that these matters are too old to expect AMR to address the situation in its proposal.

#8 Pricing Information in Technical Proposal / Alteration of Proposals

MTM and Logisticare alleged AMR is a non-responsive and/or non-responsible bidder in that AMR improperly included pricing information in its technical proposal in violation of the RFP, that Mr. Covey improperly modified AMR's technical proposal by removing AMR's pricing information, and that with the pricing removed, AMR's proposal was non-responsive.

This issue arises out of AMR's inclusion of the following statements in its technical proposal. AMR's included a statement in its technical proposal that its financial exposure as calculated for the first 90 days of operation "finds us with $4,717,758.70 exposure and this represents 0.91% or our current working capital." AMR continued to diagram its "Start up costs - $319,756.00", its "First year billing (9 mos) - $13,194,008.00", its "1/3 billings equals financial risks of operation - $4392,002.70" (sic), and its "Total potential 90 day financial exposure - $4,717,758.70." (Ex. 12, pp. 170 and 171.)

MTM and Logisticare alleged AMR's inclusion of this financial information in its technical proposal violated the requirements of the RFP to submit their price proposal separately from their technical proposal tainting the evaluation of the technical proposals.

The CPO disagrees. Section 2.3.1 required the Bidder to provide assurance (of) financial stability, with the financial resources to sustain services for a minimum of ninety (90) days prior to receiving payment from SCDHHS; to certify that it has the financial wherewithal to pay transportation providers for ninety days without payment from the state. AMR responded to this requirement.

While the RFP did require a "Separate Price Proposal" (Ex. 1, p. 90), unlike many RFPs processed by MMO, it did not expressly require that price proposals be delivered in a separate envelope. According to Mr. Covey, MMO's Procurement Manager, out of an abundance of caution, he redacted the dollar amounts from the AMR proposal before he delivered the technical proposals to the evaluators (See Ex. 19) waiving the matter as a minor informality or irregularity per SC Code section 11-35-1520(13). MTM and Logisticare argued that even with the financial information redacted, the evaluators could calculate AMR's price proposal. The CPO finds this allegation unlikely.

Consequently, MTM and Logisticare alleged that Mr. Covey improperly altered AMR's proposal. Further, they note that Mr. Covey did not prepare a written determination to warrant the minor informality or irregularity according to the Code. In the opinion of the CPO, Mr. Covey's actions were prudent in that he assured that no possible evidence of the AMR price proposal would be available to the evaluators of the technical proposal. Mr. Covey merely insured no compromise of the technical proposals. Further, it was unnecessary for Mr. Covey to declare the matter a minor informality under the Code. The information included was not AMR's price proposal, which AMR submitted separately. Mr. Covey merely took a precautionary step intended to avoid any possibility of compromising the evaluation of the AMR technical proposal with the financial exposure information provided by AMR.

#9 Misrepresentations - Postcard
#10 Misrepresentation – Trip Software

MTM alleged that AMR's proposal contained material misrepresentations that created the opportunity for improper influence over the evaluation of the proposals in that AMR in the form of a "sample postcard" falsely claiming that it had won a NEMT contract by the State of

Wisconsin, which it did not, and that AMR's trip software for trip scheduling is unreliable for large transportation programs. (December 20, 2010 letter, Item 2). Similarly, Logisticare alleged that AMR's proposal contained material misrepresentations in that AMR in the form of a "sample postcard" falsely claiming that it had won a NEMT contract by the State of Wisconsin, which it did not, and that AMR's trip software for trip scheduling is unreliable for large transportation programs. (December 17, 2010 letter, Item 2)

This allegation arises, in part, from AMR's inclusion of an entry in its proposal that read, "See the sample post card below. American Medical Response (AMR) has recently contracted with the Wisconsin Department of Health Services, Division of health Care Access and Accountability to manage the Non-Emergency Medical Transportation." (Ex. 12, pp. 195 and 196) MTM and Logisticare alleged this post card was designed to misrepresent AMR's experience, by implying that AMR held a contract with the State of Wisconsin for NEMT, which ARM does not.

An allegation of a misrepresentation by an offeror requires an actual misstatement of fact be proven and that the misstatement had a material impact, e.g., influenced the evaluation of proposals. However, AMR clearly listed the post card as a "sample", not as an assertion that it actually held the contract with the State of Wisconsin. Therefore, no actual misstatement of fact occurred. Further, no evidence was presented to show that the purported misrepresentation tainted the evaluation.

Regarding MTM's and Logisticare's allegation that AMR's software for trip scheduling is unreliable for large transportation programs, neither MTM nor Logisticare offered any evidence to prove their allegations. Therefore, the CPO finds that they have not met any burden of proving the allegation by the preponderance of evidence.

#7 Post-Opening / Pre-Award Changes to Contract Scope

MTM alleged that DHHS, in a December 14, 2010 Medicaid Bulletin, announced significant changes to the South Carolina Medicaid Program, changes that would reduce certain optional services, that these changes were not made known to the offers prior to the opening, and that these changes could cause the state to pay too much for NEMT (December 20, 2010 letter, Item 1). Logisticare joined in this allegation. (December 17, 2010 letter, Item 1)

MTM and Logisticare argued that DHHS failed to announce the planned reduction in Medicaid services for vision, dental, rehabilitation services, and adult behavioral health despite receiving a question directed at such changes during the question and answer phase of the procurement. Albert Cortina of Logisticare argued that the bulletin reduced the trips available to the offerors in Regions 2 and 3, which would have allowed Logisticare to lower its price proposal.

In effect, MTM and Logisticare argued that SCDHHS mislead them regarding service levels going forward. They point to the answer provided in amendment # 1 in response to questions submitted by the prospective offerors. In response to the question, "Has the Agency developed any forward-looking projections on the potential growth of South Carolina Medicaid enrollment that may assist all bidders and can you share with us what those growth assumptions are?" DHHS answered, "the agency has developed some forward looking projections but not specifically for the purpose of non-emergency transportation. These projections may be found on the agency's website at www.scdhhs.gov. Discovery of any inaccuracy in this data will not constitute a basis for contract rejection by any Offeror. Further discovery of any inaccuracy in this data will not constitute a basis for renegotiation of any payment rate after contract award. It remains the offeror's responsibility to take into consideration normal volume increases over the

contract period." (Ex. 2, p. 19, Question #10) MTM and Logisticare also point to DHHS's response to question 8 that was raised during the question and answer phase. To the question, "are any benefit changes anticipated or under consideration that may impact utilization under this program?" DHHS responded, "SCDHHS is expecting to add the Health Connections Kids (HCK) population of approximately 16,000 children in the fourth quarter of calendar year 2010. However, this population currently provides its own transportation and the agency does not anticipate significant utilization of the transportation program. At this point, no *additional* programs are anticipated." (Ex. 2, p. 32, Question 8) (emphasis added)

The DHHS answers do not promise that there would not be reductions in the program. DHHS wrote, in part, "the agency has developed some forward looking projections but not specifically for the purpose of non-emergency transportation" and "no additional programs are anticipated." It is important to note that questions raised by prospective offerors published in an amendment do not alter the requirements of an RFP; only the answers offered by the state amend the requirements of the RFP. The answers provided clearly indicated that DHHS did not expect any expansion in the NEMT program. DHHS did not write that no reductions in NEMT would be made.

DHHS responded at the hearing that, at the time of the issuance of the RFP, it was not aware of the reductions in services announced by the Medicaid Bulletin. DHHS asserts that the reductions are to services, not necessarily to transportation. Further, DHHS asserts that there are other factors such as doctor overrides built into the system when a doctor might determine that the service are medically necessary that would require that the reduced services be available to Medicaid members. DHHS asserts also that the reduction of rehabilitation services only applies to private facilities, not public ones.

Regarding the Medicaid Bulletin, the question begging an answer is how the protestants were aggrieved by the Medicaid Bulletin? The RFP warned prospective bidders on September 9, 2010 that changes could occur to the State's Medicaid program that could affect NEMT. (Ex. 1, p. 27, 3.0 Core Services, which reads, "MMO, on behalf of SCDHHS, reserves the right to make adjustments within the general scope of the contract by Change Order on as needed basis" and Ex. 1, p. 106, Changes, announced the state may make changes to requirements.) In fact, during these difficult economic times, DHHS has been forced to cut Medicaid benefits for years. As current providers, both MTM and Logisticare knew that. On several occasions, the South Carolina General Assembly has overridden DHHS and reinstated the services. Whether this will happen again or not is unknown. All offerors offered NEMT services based upon the anticipated requirements as stated in the RFP and amendments.

The proposals were opened October 25, 2010. The Medicaid Bulletin was not issued until December 14, 2010 with an effective date of February 1 – April 1, 2011, well after the proposals were opened. The reductions in Medicaid eligible services announced by DHHS in the Medicaid Bulletin may reduce the NEMT service to be offered by all offerors, not just MTM and Logisticare. The reductions in NEMT services required by the RFP were reduced uniformly for all prospective bidders equally. Therefore, no offeror was aggrieved relative to all other offerors by the Medicaid Bulletin. The protest is denied on its merits and for MTM's and Logisticare's lack of standing as an aggrieved bidder.

DETERMINATION

For the aforementioned reasons, the protests are denied.

R. Voight Shealy
Chief Procurement Officer
for Supplies and Services

2/9/2011
Date

Columbia, S.C.

STATEMENT OF RIGHT TO FURTHER ADMINISTRATIVE REVIEW

The South Carolina Procurement Code, in Section 11-35-4210, subsection 6, states:

(6) Finality of Decision. A decision pursuant to subsection (4) is final and conclusive, unless fraudulent or unless a person adversely affected by the decision requests a further administrative review by the Procurement Review Panel pursuant to Section 11-35-4410(1) within ten days of posting of the decision in accordance with subsection (5). The request for review must be directed to the appropriate chief procurement officer, who shall forward the request to the panel or to the Procurement Review Panel, and must be in writing, setting forth the reasons for disagreement with the decision of the appropriate chief procurement officer. The person also may request a hearing before the Procurement Review Panel. The appropriate chief procurement officer and an affected governmental body shall have the opportunity to participate fully in a later review or appeal, administrative or judicial.

Copies of the Panel's decisions and other additional information regarding the protest process is available on the internet at the following web site: www.procurementlaw.sc.gov

FILE BY CLOSE OF BUSINESS: Appeals must be filed by 5:00 PM, the close of business. *Protest of Palmetto Unilect, LLC*, Case No. 2004-6 (dismissing as untimely an appeal emailed prior to 5:00 PM but not received until after 5:00 PM); *Appeal of Pee Dee Regional Transportation Services, et al.*, Case No. 2007-1 (dismissing as untimely an appeal faxed to the CPO at 6:59 PM).

FILING FEE: Pursuant to Proviso 83.1 of the 2010 General Appropriations Act, "[r]equests for administrative review before the South Carolina Procurement Review Panel shall be accompanied by a filing fee of two hundred and fifty dollars ($250.00), payable to the SC Procurement Review Panel. The panel is authorized to charge the party requesting an administrative review under the South Carolina Code Sections 11-35-4210(6), 11-35-4220(5), 11-35-4230(6) and/or 11-35-4410(4). . . . . Withdrawal of an appeal will result in the filing fee being forfeited to the panel. If a party desiring to file an appeal is unable to pay the filing fee because of hardship, the party shall submit a notarized affidavit to such effect. If after reviewing the affidavit the panel determines that such hardship exists, the filing fee shall be waived." 2010 .C. Act No. 291, Part IB, § 83.1. PLEASE MAKE YOUR CHECK PAYABLE TO THE "SC PROCUREMENT REVIEW PANEL."

LEGAL REPRESENTATION: In order to prosecute an appeal before the Panel, a business must retain a lawyer. Failure to obtain counsel will result in dismissal of your appeal. *Protest of Lighting Services*, Case No. 2002-10 (Proc. Rev. Panel Nov. 6, 2002) and *Protest of The Kardon Corporation*, Case No. 2002-13 (Proc. Rev. Panel Jan. 31, 2003).

MTM
Medical Transportation Management, Inc.

December 10, 2010

Chief Procurement Officer
State of South Carolina
Materials Management Office
1201 Main Street, Suite 600
Columbia, SC 29201

Re: Protest of Intent To Award
Solicitation: 5400002201 (Non-Emergency Medical Transportation Services)
Contract No.: 4400003143 (Logisticare Solutions, LLC)
4400003144 (American Medical Response, Inc.)

Dear Chief Procurement Officer:

This letter constitutes the formal protest of Medical Transportation Management, Inc. ("MTM") to the State of South Carolina pertaining to the State's Intent to Award Contract Number 4400003143 to Logisticare Solutions, LLC for Region 1, and Contract Number 4400003144 to American Medical Response, Inc. for Regions 2 and 3 for non-emergency medical transportation (NEMT) services.

1) Pricing

a) **Federal law and CMS Regulations.** The above solicitation sought global, fixed, flat cap prices (as opposed to capitation pricing) for a 3 year contract with 2 option years for a total fixed, flat pricing for 5 years. Because of the volatility of eligible beneficiaries and utilization, capitation pricing is the usual, customary and appropriate industry method of pricing NEMT services. The fixed, flat rate pricing mechanism of the solicitation shifts all NEMT program risks to the bidders, in that compensation to the broker does not vary based upon changes in the number of eligible Medicaid beneficiaries. In this era of extremely high unemployment, job loss, and economic adversity, coupled with the uncertainty of increased demand for health care services with federal health care reform legislation, the number of people becoming eligible for Medicaid NEMT benefits over the next five (5) years is likely to continue to escalate disproportionately. Medicaid population eligibility is so volatile that fixed, flat rate pricing where the broker assumes all risk of increases in the number of eligible beneficiaries is unconscionable, resulting in pure speculation by all bidders, and not consistent with commercially sound business practices, nor with federal laws and CMS regulations requiring actuarial sound pricing of federal government participation contracts.

i) The Deficit Reduction Act of 2005 and Regulations promulgated by the Centers For Medicare and Medicaid Services (CMS) require that risk based contracts be actuarially sound with respect to pricing. The intent of the federal law and CMS Regulations was to promote competitive pricing for government services contracts, while avoiding the selection of a contractor's bid whose price is below an actuarial sound range of pricing, to ensure the government has no interruption in services based upon a contractor incurring significant operational losses resulting from "low ball," predatory bid pricing. In other words, the federal government wants to obtain competitively fair rates for the provision of Medicaid NEMT services, but it does not want such federally subsidized State contracts to be awarded to bidders who submit unrealistically low pricing bids that are arbitrary or otherwise consist of a bidder engaged in predatory pricing simply to "buy the contract" at any cost.

ii) MTM submits that the pricing bids of AMR for Regions 2 and 3 and Logisticare in Region 1 are actuarially unsound, and consist of predatory, commercially unreasonable pricing in an attempt to "buy" a State NEMT contract. AMR in particular, attempts to mask its lack of experience in State-wide Medicaid NEMT services with "lowball," commercially unreasonable, predatory pricing. MTM further submits that the State of South Carolina failed to commission and obtain an actuarial study and report to determine what price range that bid prices should fall within in order to be determined to be actuarially sound, and not discarded as being too low or too high. The failure by the State of South Carolina in not having obtained an actuarial study of the expected costs of its Medicaid NEMT program for this RFP constitutes a violation of the Deficit Reduction Act and CMS Regulations. Without commissioning an actuarial study, the State has no idea of what the projected increases in Medicaid eligibles over the next 3 and 5 years would likely be, nor what the cost impact on the NEMT program would be that the successful bidder would have to absorb while still providing service. Fixed, flat rate pricing does not allow for such changes to the State's NEMT program over the next five years, and significantly increases any bidder's potential for default based upon operational fiscal losses.

iii) CMS has enacted extensive regulations governing Medicaid risk based services contracts. At 42 CFR 438.6(c)(2) it states: "***Basic requirements.* (i) All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound."** (Emphasis added.) A fixed price per unit based RFP bid process and resulting contract is a risk based contract in that the bidder is at risk for whether the cost of providing the NEMT services exceeds the revenue generated from the fixed, flat rate bid price. A risk based, fixed, flat rate 3-5 year service contract entices speculative bidding without actuarially sound pricing parameters, and constitutes a denial of due process and equal protection of the law to MTM, in violation of the 5th and 14th amendments to the U.S. Constitution.

iv) At 42 CRFR 438.6(c)(1)(i) the regulations define actuarially sound capitation rates as follows: **"Actuarially sound capitation rates means capitation rates that-**

a. **Have been developed in accordance with generally accepted actuarial principles and practices;**

b. **Are appropriate for the populations to be covered, and the services to be furnished under the contract; and**

c. **Have been certified, as meeting the requirements of this paragraph (c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board."** (Emphasis added.)

And further, at 42 CFR 438.6(c)(4) the regulations provide:

"(4) *Documentation.* The State must provide the following documentation: (i) The actuarial certification of the capitation rates." (Emphasis added.)

v) The State has not provided any certification from an actuary that AMR's bid is within a price range certified as being actuarially sound for this risk based NEMT services contract. MTM submits that the State does not have a current actuarial certification as to the costs of its Medicaid NEMT services program, and therefore cannot certify that AMR's bid is actuarially sound and not arbitrarily and unrealistically low, based upon MTM's belief that AMR is simply trying to "buy the contract." MTM contends that the CMS regulations referenced herein were enacted to prevent the exact situation that has occurred here, whereby AMR and Logisticare have submitted actuarially unsound, unrealistically low, commercially unreasonable, and predatorially priced bids in order to "buy the contract."

vi) Because the State did not commission a new actuarial study for this solicitation as it should have, a review of the State's prior actuarial study, with trending forward to the present, is necessary to determine the actuarial soundness, and commercial reasonableness, of the rates submitted by AMR and Logisticare. The State had previously commissioned Milliman to determine the range of actuarially sound rates for the period March 2009-February 2010. A copy of the Milliman study is attached hereto as Exhibit A. The Milliman study primarily used 2008 data, which is now two (2) years outdated and doesn't capture the devastating downturn in the economy that occurred between 2008-2010 that left many people out of work, adding them to the Medicaid eligibility rolls at a rate faster than normal. MTM has taken the Milliman study, assuming the trending rates identified in the study and used by Milliman, and trended and extrapolated these Milliman actuarially sound rates forward for the initial 3 year contract period, and for the 2 option years. The results of this analysis are found in the attached Exhibit B.

b) AMR's Bid: Regions 2 and 3

i) For the initial 3 year contract period, AMR bid $46,264,005 for Region 2 and $46,581,911 for Region 3. **The Milliman study, applying the same assumptions and trending percentages, would suggest that actuarially sound bids for Region 2 would have a range between a low of $65,813,836 and a high of $87,288,278. AMR bid $46,264,005, more than $19.5 million less (and 29.7% lower than) the lowest actuarially sound rate! For Region 3 the Milliman study would suggest that actuarially sound rates would have a range of a low of $70,121,790 and a high of $93,695,874. AMR bid $46,581,911, which is $23.5 million less (and 33.5% less than) the lowest actuarially sound rate!**

Similarly, in the option years of the solicitation (Years 4 and 5), the Milliman study trended forward would suggest for Region 2 a range of a low of $27,314,976 and a high of $39,714,187 for Option Year 1, and a range of a low of $29,235,805 and a high of $44,671,379 for Option Year 2. AMR bid $17,021,950 for Option Year 1 and $17,475,308 for Option Year 2 in Region 2, over $22 million less (and 39% lower than) the lowest actuarially sound rate! For the option years in Region 3, the Milliman study would trend and project a range of a low of $28,974,201 and a high of $42,446,255 for Option Year 1, and a range of a low of $30,945,153 and a high of $47,643,149 for Option Year 2. AMR bid $17,138,917 in Option Year 1 and $17,595,386 in Option Year 2 in Region 3, more than $25 million less (and 42% lower than) the lowest actuarially sound rate!

ii) The unrealistically low, actuarially unsound pricing also results from AMR's minimal experience managing a State-wide Medicaid NEMT program. Such commercially unreasonable, predatory pricing from inexperienced companies such as AMR is exactly what the federal government and CMS were intending to prohibit in the enactment of the Deficit Reduction Act and promulgation of the above CMS Regulations.

c) Logisticare's Bid: Region 1

i) **For the initial 3 year contract period, the Milliman study for Region 1, trended forward with the 2010 State adjusted minimal administration fee rate of 14% for Region 1, would suggest an actuarially sound rate in the range of a low of $41,022,378 and a high of $53,743,707. Logisticare bid $39,892,608, over $1.1 million less (and 2.8% lower than) the lowest actuarially sound rate!**

ii) **Similarly, in the option years of the solicitation, the Milliman study, trended forward, would suggest an actuarially sound rate range of a low of $17,182,174 and a high of $24,673,747 in Option Year 1 and a low of $18,469,836 and a high of $27,873,740 for Option Year 2. Logisticare bid**

$15,824,981 in Option Year 1 and $16,889,837 in Option Year 2, almost $3million less (and 8.2% lower than) the lowest actuarially sound rate!

2) **Evaluation and Scoring**

a) The evaluation and scoring of MTM's Technical proposal was arbitrary and capricious, and lacking in fundamental fairness as to MTM. MTM has most recently scored #1 in technical response in 4 of the last 5 NEMT government solicitations, and in all 5 solicitations MTM scored higher than AMR. The same quality of these technical responses was given to the South Carolina response. It is difficult to comprehend how the South Carolina evaluators could reasonably score MTM lowest of the 4 bidders in technical response, and score AMR higher than MTM in technical response. For some unknown reason, **Evaluator Mike Benecke, who is quite familiar with the quality service MTM provides the State in Regions 1 and 2, gave MTM a Technical score of 20, the lowest technical score of any Evaluator, and 31% lower than the next lowest score (29), and 53.8% lower than the highest technical score (43) given to MTM.** The obvious conclusion is that Mr. Benecke unduly favored other bidders and was unjustifiably harsh in scoring MTM's Technical proposal, compared to all other Evaluators. As the incumbent broker in current Regions 1 and 2, MTM's knowledge of the NEMT services program is superior to all other bidders, and MTM would have to be failing miserably in its performance of services to justify a score of 20 as to how MTM would continue to serve South Carolina under a new contract. In his comments, Mr. Benecke noted, in his opinion, that MTM's proposal either contradicted the RFP requirement or noted the difference in the RFP requirements compared to the existing contract, but did not adequately address the modified requirements. Conversely, Mr. Benecke had no harsh comments (or low scoring deviation from other Evaluators) for AMR or Logisticare in his comments about these bidders either responding differently than required by the RFP, or failing to fully address the RFP requirements, in saying:

(i) As to AMR: "If awarded the contract for this region, there will be some adjustments required to some of the approaches to fulfilling the requirements as acknowledged in the proposal."

(ii) As to Logisticare: "If the Offeror is selected there will be some modification required to some of the proposed policies, processes, and procedures. For example, the Offeror did not make changes to the existing transportation provider manual that addresses some of the differences between the existing contract and this RFP and the monitoring program proposed for volunteer drivers may not fully meet the expectations of the contract."

(iii) And further as to Logisticare, Mr. Benecke favorably commented about the additional effort of Logisticare being put into obtaining URAC accreditation demonstrates the organization's commitment to quality and process improvement. Unfortunately, Mr. Benecke did not similarly comment favorably towards MTM having obtained URAC accreditation as a demonstration of MTM's commitment to quality and process improvement. And as will be discussed further herein,

URAC or NCQA accreditation was a mandatory requirement of the RFP, which AMR is lacking.

b) **Evaluator David Giesen** unfairly criticized MTM stating that MTM failed to provide a plan required by section 3.2 of the RFP. However, all information required by section 3.2 was contained later under the Background, Experience and Approach to Staffing tab, wherein MTM referenced section 3.2.

(i) Mr. Giesen also unfavorably, and erroneously, commented that MTM's Local Organization Chart did not have the names of the persons included thereon. However, a copy of MTM's Local Organization Chart submitted in the proposal is attached hereto as Exhibit C. This chart clearly contains the names of MTM's personnel for the various positions.

(ii) Mr. Giesen also unfavorably commented that MTM referenced a regional person, whom he had never met, in an attachment (MTM's draft South Carolina Facility Manual). How many personnel of AMR, regional or otherwise, referenced in AMR's response, has he not met? MTM suspects Mr. Giesen has met few of the key AMR personnel.

c) **Evaluator Sheila Platts** unfavorably noted "accessibility of key staff is questionable." How can this assertion be justified in that MTM maintains a business office and call center in South Carolina managed by a Program Director capable and willing to meet with South Carolina officials at any time; and Vice President of Client Services, Kim Matreci, regularly travels to South Carolina from corporate headquarters for business meetings with agency officials?

(i) Ms. Platts further negatively comments that MTM did not provide letters of intent from existing providers. MTM did provide a list of current contracted providers- why would MTM need to procure letters of intent from these providers when they are already under contract with MTM?

These and other Evaluator comments are excessively and unjustifiably critical of MTM, which correspondingly resulted in arbitrarily low technical scoring of MTM's proposal.

3) AMR in the News

Is it in the best interest of the State of South Carolina and its Medicaid beneficiaries to hire a large ambulance company to run its NEMT services program?

The State must consider the quality of services it would receive from AMR and the integrity of the company with whom it chooses to contract. An internet search of American Medical Response (AMR) discloses some disturbing legal proceedings, business practices and audit findings of AMR. The following is a summary of two Texas lawsuits wherein AMR reportedly paid $9 Million to settle claims of fraudulent kickbacks and false claims involving ambulance services:

a) ***"American Medical Response Settlement*** **(S.D.Tex. Oct. 5, 2006)**

October 5, 2006—American Medical Response (AMR), one of the largest ambulance providers in the country, agreed to pay $9 million dollars to resolve charges that it defrauded the government by violating the Anti-Kickback Statute and the False Claims Act. The allegations stem from two qui tam cases filed in 2000 and 2001: *U.S. ex rel. Block v. Laidlaw Medical Transport* and *U.S. ex rel. Wightman v. Laidlaw Inc. et al.* Both of these suits assert that American Medical Response offered or provided financial kickbacks to hospitals to obtain their business. One such kickback scheme involved 'swapping arrangment' contracts, in which AMR would offer discounts to hospitals for standard emergency facility transport services in exchange for their non-emergency, discharge transport business. Relators Daniel Block and Adam Wightman will split a $1,620,000 relator's share and will be reimbursed by AMR for their legal fees which amount to $122,455.07. The civil division of the Justice Department, the U.S. Attorney's Office for the Southern District of Texas, the Office of the Inspector General for the Department of Health and Human Services, and the FBI investigated this case. TAF members Glenn Grossenbacher and John E. Clark of Goode Casseb Jones Ricklin Choate and & Watson represented Adam Wightman and TAF member Anthony DeWitt of Bartimus Frickleton Robertson Gorny represented Daniel Block. Assistant U.S. Attorney Kevin Aiman handled the case along with Michael F. Hertz, Polly A. Damman, Jamie Ann Yavelberg, and Suzette Gordon of the U.S. Department of Justice, Civil Division."

Did AMR disclose these lawsuits and settlements to the State?

b) Further, the Houston Chronicle newspaper reported that a Texas audit of its NEMT program disclosed serious shortcomings involving the criminal backgrounds and driver's licenses of AMR drivers. The following report was published by the Houston Chronicle:

"Audit faults State driving program

Some who had criminal records allowed to take the poor to doctor appointments

By R.G. RATCLIFFE Copyright 2007 Houston Chronicle Austin Bureau

Oct. 30, 2007, 10:39PM

AUSTIN — Individuals who lacked driver's licenses or who had a criminal history have been allowed to drive poor people to doctor appointments because of lax supervision by the Texas Department of Transportation, auditors reported Tuesday.

The Texas Medical Transportation Program is a $95 million a year taxpayer-financed program that provides non-emergency transportation to more than 196,000 indigent Texans for doctors appointments and medical treatments. The program was transferred from the Texas Department of Health to the transportation agency in 2006.

The State Auditors Office reported that transportation officials have been inadequately supervising the companies that are hired to provide the actual transportation services. Auditors

said the department had conducted no monitoring of transportation providers in the San Antonio and Rio Grande Valley areas.

"Auditors visited four of the largest transportation providers and determined that a substantial number of their drivers had criminal backgrounds or invalid driver's licenses," auditors said.

"In addition, a large number of transportation providers' subcontractors did not comply with liability or workers' compensation insurance requirements."

The auditors found the transportation company with the most problems was American Medical Response, based in Greenwood Village, Colo.

AMR provided auditors with a list of 854 drivers, but the report said AMR was unable to give them a complete list.

Of the disclosed drivers, auditors reviewed the records of 179 AMR drivers and found 34 with criminal histories that would have disqualified them, and 29 with invalid driver's licenses. The report said most of the criminal backgrounds involved misdemeanors.

AMR provides transportation for the indigent in Houston, Beaumont, San Antonio and the Panhandle, said transportation agency spokesman Mark Cross.

Cross said many of the problems resulted from transferring the program from the health department.

Transportation officials in their response to the audit said program staff levels and management plans will be in place by next February to provide proper supervision to the transportation companies.

r.g.ratcliffe@chron.com"

Did AMR disclose this negative Texas audit of its NEMT services to the State?

c) Additionally, most recently on December 3, 2010, the same date that South Carolina posted its notice of intent to award the NEMT services contract for Regions 2 and 3 to AMR, a newspaper article ran in the Spokane, Washington newspaper "The Spokesman-Review" written by reporter Thomas Clouse about a legal settlement by AMR with the City of Spokane pertaining to claims by the city of AMR overbilling Medicare ambulance claims over a six (6) year period. Excerpts from the article are as follows:

"American Medical Response, Spokane's ambulance service provider, agreed to pay back just under $1 million, plus interest, received as a result of overbilling more than 12,000 Spokane residents over six years."

"At the core of the lawsuit was how AMR billed city residents who called 911 for emergency services. In many cases, AMR charged those customers under the more expensive 'advanced life support' rate when they should have charged the cheaper 'basic life support' rate..." The article also reports that AMR also agreed to pay the class action plaintiffs' attorneys fees of $945,000.

tomc@spokesman.com

4) **Accreditation.** AMR was awarded Regions 2 and 3 despite the fact that AMR is not accredited by URAC or NCQA. Section 2.3.2 of the RFP States:

"The Broker must be accredited by a nationally recognized quality improvement organization which ensures the company is conducting business in a way that conforms to national standards for quality assurance in the health care industry. Such organizations are the Utilization Review Accreditation Commission (URAC) and the National Committee for Quality Assurance (NCQA)." AMR's bids should have been disqualified and thrown out as nonresponsive in a material aspect of the RFP.

AMR doesn't even have a single year of State-wide NEMT experience, but yet technically they were scored higher than MTM which has over 15 years of NEMT experience, including 12 years of State-wide NEMT contract experience, and the successful operation of South Carolina's program in the former Regions 1 and 2. This is another example of the arbitrariness and capriciousness of the evaluators against MTM. The evaluation and scoring has denied MTM due process and equal protection of the law, in violation of the 5th and 14th amendments to the U.S. Constitution, and applicable South Carolina law.

5) **Contract Service Implementation.** Commencement of service in South Carolina is March 1, 2011. The State has selected AMR to provide NEMT services in Regions 2 and 3, the greater portion of the State. Possibly unknown to South Carolina, which desires and expects smooth implementation of contract services, is that AMR is already committed to commence NEMT services implementation in Nebraska on the same day, March 1, 2011. MTM suggests that the State did not appropriately consider the high likelihood of significant and material service failures, breakdowns and interruptions when it chose AMR.

6) **Conclusion.** There still remains a one-year option on MTM's current contract with the State which the State could and should exercise while it pursues an actuarial study of its rate structures and re-bidding of the entire contract.

MTM further reserves the right to amend this Bid Protest to include additional points upon receipt and review of all documentation pertaining to this solicitation which MTM has requested through its open records request. Based on the foregoing, MTM requests that the State of South Carolina cancel the RFP solicitation and to re-bid the RFP as a capitation contract. To do otherwise would contravene federal statutes and CMS regulations; constitute arbitrary and capricious action, resulting in a denial of MTM's rights to due process and equal protection of the law.

Sincerely,

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November 4, 2009

Ms. Beverly G. Hamilton
South Carolina Department of Health and Human Services
1801 Main Street
Columbia, SC 29202-8206

Re: March 2009 – February 2010 Medicaid Non-Emergency Transportation Rates – Revised to Reflect Broker Encounter Data

Dear Beverly:

This letter documents the calculation of actuarially sound capitation rates for South Carolina's Medicaid Non-Emergency Transportation (NET) program for March 2009 – February 2010. This letter updates the capitation rates presented in our June 24, 2009 letter to reflect more detailed NET broker encounter data.

BACKGROUND

The South Carolina Department of Health and Human Services (SC DHHS) is in the fourth year of its contracts with two NET brokers. Medical Transportation Management, Inc. (MTM) provides NET services to the population in Regions 1 and 2. LogistiCare provides NET services to the population in Regions 3 - 6.

SC DHHS retained Milliman to develop actuarially sound NET capitation rate ranges for the March 2009 - February 2010 contract period.

SC DHHS added several small populations with more intense needs to the NET program population prior to March 1, 2009:

- Meyer Center for Special Children
- A Child's Haven
- Three Medically Fragile Children program sites
- Adult Day Centers (stretcher trips only)
- South Carolina Department of Mental Health
- Wil Lou Gray School
- School District of Pickens
- Willowglen

The new populations described in this letter can be divided into two groups based on whether or not they are reflected in the encounter data used to develop the rate ranges. We calculated funding increases to be added to the brokers' original Year 4 cost proposals and / or capitation rate add-ons for the newly covered populations.

RESULTS

Table 1 shows the actuarially sound capitation rate ranges for the existing population in each NET region as well as the capitation rate add-on and / or increase to the brokers' Year 4 cost proposal revenue for the populations SC DHHS added to the program.

Table 1
South Carolina Medicaid Non-Emergency Transportation Program
March 2009 – February 2010 Capitation Rates PMPM

NET Region	Actuarially Sound Capitation Rate Range		New Population Capitation Rate Add-on	New Population Increase to Brokers' Year 4 Cost Proposal Revenue
	Low	High		
1	$4.70	$5.23	$0.00	$821,295
2	4.03	4.49	0.00	90,921
3	5.04	5.76	1.02	0
4	7.38	8.43	0.32	0
5	6.48	7.40	0.09	50,844
6	6.92	7.90	0.15	0

Exhibit 1 shows the calculation of the actuarially sound capitation rate range for each NET region's existing population.

Exhibit 2 shows the calculation of actuarially sound capitation rates for the new populations SC DHHS added to the NET program population prior to March 1, 2009.

Exhibit 3 shows funding increases to be added to the brokers' original Year 4 cost proposals and / or capitation rate add-ons for the newly covered populations.

METHODOLOGY AND ASSUMPTIONS

Actuarially Sound Rate Range for Existing Population

We used the following methodology and assumptions to develop the actuarially sound capitation rate ranges in Exhibit 1:

1. NET service utilization rates and unit costs are based on broker-reported trips and miles by NET region for the following types of NET trip:

   > Non-emergency ambulatory sedan / van
   > Non-emergency ambulance / BLS (broker sponsored)
   > Wheelchair
   > Stretcher
   > Individual transportation / gas
   > Public transportation / bus
   > Extra passenger

MTM provided encounter data for April – June 2009. We allocated the encounter data between Regions 1 and 2 based on the zip code of residence of the recipient as found in the encounter data.

LogistiCare provided encounter data for SFY 0708. In addition to encounter claims, Logisticare also provided non-claim system payments made to NET providers that should be considered service cost, not administrative cost. We allocated the non-claim system payments by region based on the claim system claims reported by region.

2. SC DHHS provided the number of capitation payments that it made to the brokers in each region by month. We used the number of capitation payments as member months to compute the annual trips per thousand members and the per member per month (PMPM) service cost for each region. Table 2 shows the encounter data annual trips per thousand members by NET region.

Table 2
Encounter Data Annual Trips per 1,000 Members

NET Region	Trips per 1,000 Members
1	2,755
2	2,239
3	2,573
4	2,692
5	2,757
6	2,565

3. We modified the encounter data unit cost assumptions to reflect the March 2009 – February 2010 contract period based on the following assumptions:

   > We assumed fuel costs make up approximately 20% of the total unit cost for NET services. We based the fuel component of the unit cost change on published US Department of Energy monthly projections of retail gasoline and diesel fuel prices from the encounter data period to the contract period.

   > We assumed the remaining 80% of the total unit cost for NET service will increase at a rate similar to the General Consumer Price Index (CPI). We based the non-fuel component of the unit cost change on monthly projections of the General CPI.

   > We obtained all monthly cost indices from the following website:

   http://tonto.eia.doe.gov/cfapps/STEO_TableBuilder/index.cfm

4. MTM provided April 2009 – June 2009 encounter data for Regions 1 and 2. Since the data is not a full calendar year and represents a more recent time period, we included two adjustments specific to Regions 1 and 2 that do not apply to Regions 3 – 6:

   > We applied a seasonality adjustment of 0.97 based on data that shows the transportation usage rate is higher in April – June compared to the rest of the year.

> We applied a claims completion factor of 1.05 to reflect claims that were incurred during April 2009 – June 2009, but not included in the encounter data provided in August 2009. We expect transportation claims to compete relatively quickly.

5. We used the following assumptions to develop the high and low endpoints of the actuarially sound capitation rate ranges based on our judgment:

   > Utilization trend of between 3% and 5% per year.

   > Managed care savings assumptions of between 0% and 3% since we are using managed care encounter data.

   > A broker administrative allowance of between 12% and 18% of revenue.

Capitation Rates for New Populations

Exhibit 2 develops capitation rates for the new populations SC DHHS added to the NET contract prior to March 1, 2009.

Exhibit 2A – Specialized Children's Programs

We assumed the participants in the Meyer Center, A Child's Haven, and Medically Fragile Children programs had similar transportation needs. We developed a monthly capitation rate for these three populations using the following methodology based on actual data from the Meyer Center and A Child's Haven:

1. NET service utilization rates are based on SFY 2008 reported trips and miles from the invoices received by SC DHHS from the Meyer Center and A Child's Haven.

2. We used the unit costs from each program's October 2008 – December 2008 contract with SC DHHS to provide the most up-to-date measure of the programs' cost of providing NET services to their participants.

3. We developed total reimbursement amounts by multiplying the SFY 2008 miles by the applicable October 2008 – December 2008 unit cost assumptions.

4. We assumed the average enrollment in each program equals the annual unduplicated recipients reported in the invoices received by SC DHHS. We calculated member months as the annual number of unduplicated times 11 to allow for recipients who are not with the programs for a full year.

5. We decreased the October 2008 – December 2008 unit cost assumptions by 1.1% to reflect the March 2009 – February 2010 contract period based on the following assumptions:

> We assumed fuel costs make up approximately 20% of the total unit cost for NET services. We based the fuel component of the unit cost change on published US Department of Energy monthly projections of retail gasoline and diesel fuel prices from the encounter data period to the contract period.

> We assumed the remaining 80% of the total unit cost for NET service will increase at a rate similar to the General Consumer Price Index (CPI). We based the non-fuel component of the unit cost change on monthly projections of the General CPI.

6. We used the following assumptions to develop the capitation rates based on our judgment:

> Utilization trend of 4% per year.

> Managed care savings of 10% since we are using non-managed experience data.

> A broker administrative allowance of 5% of revenue to provide for the incremental administration costs associated with serving the new populations.

Exhibit 2B – Adult Day Center Stretcher Trips

We priced the NET costs of one round-trip adult day center stretcher trip per day based on the following methodology:

1. NET service utilization rates are based on 10 one-way trips per week for 52 weeks per year (10 x 52 = 520 trips).

2. We used the stretcher trip unit costs that were reported in the broker encounter data. We calculated an average unit cost for Regions 1 – 2 and Regions 3 – 6 separately.

> Regions 1 – 2 = $81.58 per stretcher trip

> Regions 3 – 6 = $132.35 per stretcher trip

3. We developed total reimbursement amounts by multiplying the assumed trips and miles by the unit cost assumptions.

4. We assumed 12 member months so that the resulting PMPM amount represented the cost of providing one round trip stretcher trip per day.

5. We modified the encounter data unit cost assumptions to reflect the March 2009 – February 2010 contract period based on the following assumptions:

> We assumed fuel costs make up approximately 20% of the total unit cost for NET services. We based the fuel component of the unit cost change on published US Department of Energy monthly projections of retail gasoline and diesel fuel prices from the encounter data period to the contract period.

> We assumed the remaining 80% of the total unit cost for NET service will increase at a rate similar to the General Consumer Price Index (CPI). We based the non-fuel component of the unit cost change on monthly projections of the General CPI.

6. We used the following assumptions to develop the capitation rates based on our judgment:

> No utilization trend or managed care savings because we are pricing a fixed utilization rate of one round trip per day.

> A broker administrative allowance of 5% of revenue to provide for the incremental administration costs associated with serving the new populations.

Exhibit 2C – Other New Populations

We developed a monthly capitation rate for the SC Department of Mental Health, Wil Lou Gray School, Willowglen, and the School District of Pickens populations using the following methodology based on actual data from these new populations:

1. NET service utilization rates and unit costs are based on reported trips and miles from the invoices received by SC DHHS for the last available state fiscal year.

2. We developed total reimbursement amounts by multiplying the miles by the unit cost assumptions.

3. We assumed the average enrollment in each program equals the annual unduplicated recipients reported in the invoices received by SC DHHS. We calculated member months as the annual number of unduplicated times 11 to allow for recipients who are not with the programs for a full year.

4. We modified the unit cost assumptions to reflect the March 2009 – February 2010 contract period based on the following assumptions:

> We assumed fuel costs make up approximately 20% of the total unit cost for NET services. We based the fuel component of the unit cost change on published US Department of Energy monthly projections of retail gasoline and diesel fuel prices from the encounter data period to the contract period.

> We assumed the remaining 80% of the total unit cost for NET service will increase at a rate similar to the General Consumer Price Index (CPI). We based the non-fuel component of the unit cost change on monthly projections of the General CPI.

5. We used the following assumptions to develop the capitation rates based on our judgment:

> Utilization trend of 4% per year.

> Managed care savings of 10% since we are using non-managed experience data.

- A broker administrative allowance of 5% of revenue to provide for the incremental administration costs associated with serving the new populations.

Regional Revenue Projection for New Populations

The new populations described in this letter can be divided into two groups based on whether or not they are reflected in the encounter data used to develop the capitation rate ranges. MTM provided April 2009 – June 2009 encounter data for Regions 1 and 2, therefore the new populations are already reflected in Regions 1 and 2. Logisticare provided SFY 2008 encounter data for Regions 3 – 6. The Williowglen population is the only new population included in the SFY 2008 encounter data for Regions 3 – 6.

For populations already included in the encounter data used to develop the capitation rate ranges, Exhibit 3 calculates the increase to the funding established in the brokers' Year 4 cost proposal. There is no capitation rate add-on for these new populations because they are already included in the data used to set the capitation rate ranges.

For populations that are not included in the encounter data used to develop the capitation rates, Exhibit 3 develops the per member per month add-on capitation rate for the new populations. The add-on should be added to the capitation rate for the existing population to set the final capitation rate for the combined existing and new population.

CAVEATS AND LIMITATIONS ON USE

This letter is intended for the internal use of SC DHHS and it should not be distributed, in whole or in part, to any external party without the prior written permission of Milliman. We do not intend this information to benefit any third party even if we permit the distribution of our work product to such third party. We understand SC DHHS will distribute this letter to CMS and the NET brokers.

This letter provides rates for the Medicaid NET program. This information may not be appropriate, and should not be used, for other purposes.

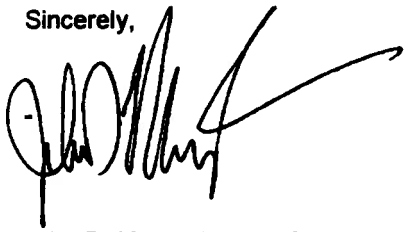
The actual cost of NET services will likely differ from the estimates in this letter based on how these services are actually delivered by the brokers. In preparing this information, we relied on information provided by SC DHHS. We accepted this information without audit, but reviewed the information for general reasonableness. Our recommendations may not be appropriate if this information is not accurate.

The terms of Milliman's contract with SC DHHS effective May 1, 2008 apply to this letter and its use.

◆ ◆ ◆ ◆ ◆

Please call me at (262) 796-3434 if you have any questions.

Sincerely,



John D. Meerschaert, FSA
Principal and Consulting Actuary

JDM/vrr

Attachments

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Appendix A
South Carolina Department of Health and Human Services
Actuarial Certification
Medicaid Non-Emergency Transportation Program
March 1, 2009 – February 28, 2010 Capitation Rates

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November 4, 2009

Appendix A
South Carolina Department of Health and Human Services
Actuarial Certification
Medicaid Non-Emergency Transportation Program
March 1, 2009 – February 28, 2010 Capitation Rates

I, John D. Meerschaert, am associated with the firm of Milliman, Inc. and am a member of the American Academy of Actuaries and meet its Qualification Standards for Statements of Actuarial Opinion. I have been retained by the South Carolina Department of Health and Human Services (SC DHHS) to perform an actuarial certification of the Medicaid Non-Emergency Transportation program capitation rates for March 1, 2009 – February 28, 2010 for filing with the Centers for Medicare and Medicaid Services (CMS). I reviewed the development of the capitation rates and am familiar with the Code of Federal Regulations, 42 CFR 438.6(c) and the CMS "Appendix A, PAHP, PIHP, and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting."

I examined the actuarial assumptions and actuarial methods used to develop the capitation rates for March 1, 2009 – February 28, 2010. To the best of my information, knowledge, and belief, for the period from March 1, 2009 – February 28, 2010, the capitation rates offered by DHHS are in compliance with 42 CFR 438.6(c). The attached actuarial letter describes the capitation rate methodology.

In my opinion, the capitation rates are actuarially sound, have been developed in accordance with generally accepted actuarial principles and practices, and are appropriate for the populations to be covered and the services to be furnished under the contract.

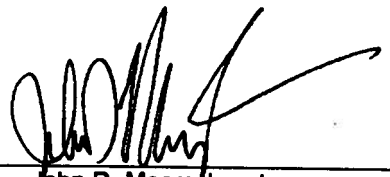
In making my opinion, I relied upon the accuracy of the underlying records and data prepared by DHHS. A copy of the reliance letter received from SC DHHS is attached and constitutes part of this opinion. I did not audit the data and calculations, but did review them for reasonableness and consistency and did not find material defects. In other respects, my examination included such review of the underlying assumptions and methods used and such tests of the calculations as I considered necessary.

The capitation rates may not be appropriate for a specific organization. Any organization will need to review the rates in relation to the benefits provided. The organization should compare the rates with its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with DHHS. The organization may require rates above, equal to, or below the actuarially sound capitation rates.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time-to-time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted organization's situation and experience.

This Opinion assumes the reader is familiar with the South Carolina Medicaid program, Medicaid eligibility rules, and actuarial rating techniques. The Opinion is intended for the State of South Carolina and Centers for Medicare and Medicaid Services and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial rate projections of the type in this Opinion, so as to properly interpret the projection results.



John D. Meerschaert
Member, American Academy of Actuaries

November 4, 2009

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Exhibit 1

Exhibit 1
South Carolina Department of Health and Human Services
Non-Emergency Transportation Capitation Rate Range Calculation
Includes New Populations Active During Encounter Data Period[1]
March 2009 - February 2010

Region 1

	Non-Emergency Ambulatory Sedan/Van Trips	Non-Emergency Ambulance/BLS (Broker Sponsored)	Wheelchair Trips	Stretcher Trips	Individual Transportation Gas Trip	Public Transportation Bus Trip	Extra Passenger	All Trip Types
April - June 2009 Trips	77,094	1	13,227	1,207	2,634	0	0	94,163
Miles per Trip	9.7	1.9	11.4	11.1	20.0	0.0	0.0	10.2
April - June 2009 Miles	747,423	2	150,173	13,444	52,808	0	0	963,848
April - June 2009 Costs								
per Mile	1.63	38.63	2.26	7.11	0.32	0.00	0.00	$1.73
Total	1,216,932	72	338,912	85,622	16,966	0	0	$1,668,504
April - June 2009 Member Months								410,090
April - June 2009 Utilization per 1,000 Members								2,755
PMPM Cost								$4.07
Unit Cost Trend to March 2009 - February 2010								1.018
Seasonality Adjustment								0.970
Claims Completion Factor								1.050
Utilization Trend (April - June 2009 to March 2009 - February 2010)								
Low (3% annual rate)								1.010
High (5% annual rate)								1.016
Managed Care Savings								
Low (3% savings)								0.970
High (0% savings)								1.000
Administration Allowance								
Low (12% of revenue)								1.136
High (18% of revenue)								1.220
March 2009 - February 2010 Capitation Rate Range								
Low								**$4.70**
High								**$5.23**

[1] Region 1 encounter data includes trips for Meyer Center, A Child's Haven, Medically Fragile Children, Adult Day Center stretcher trips, and the School District of Pickens.

Exhibit 1
South Carolina Department of Health and Human Services
Non-Emergency Transportation Capitation Rate Range Calculation
Includes New Populations Active During Encounter Data Period [1]
March 2009 - February 2010

Region 2

	Non-Emergency Ambulatory Sedan/Van Trips	Non-Emergency Ambulance/BLS (Broker Sponsored)	Wheelchair Trips	Stretcher Trips	Individual Transportation Gas Trip	Public Transportation Bus Trip	Extra Passenger	All Trip Types
April - June 2009 Trips	42,143	0	9,713	1,007	2,425	0	0	55,288
Miles per Trip	11.2	0.0	9.5	10.8	22.8	0.0	0.0	11.4
April - June 2009 Miles	473,449	0	92,070	10,882	54,778	0	0	631,180
April - June 2009 Costs								
per Mile	1.44	0.00	2.72	7.81	0.32	0.00	0.00	$1.64
Total	681,704	0	250,002	85,005	17,557	0	0	$1,034,268

April - June 2009 Member Months	296,293
April - June 2009 Utilization per 1,000 Members	**2,239**
PMPM Cost	**$3.49**
Unit Cost Trend to March 2009 - February 2010	1.018
Seasonality Adjustment	0.970
Claims Completion Factor	1.050
Utilization Trend (April - June 2009 to March 2009 - February 2010)	
Low (3% annual rate)	1.010
High (5% annual rate)	1.016
Managed Care Savings	
Low (3% savings)	0.970
High (0% savings)	1.000
Administration Allowance	
Low (12% of revenue)	1.136
High (18% of revenue)	1.220
March 2009 - February 2010 Capitation Rate Range	
Low	**$4.03**
High	**$4.49**

[1] **Region 2 encounter data includes trips for Adult Day Center stretcher trips.**

Exhibit 1
South Carolina Department of Health and Human Services
Non-Emergency Transportation Capitation Rate Range Calculation
Includes New Populations Active During Encounter Data Period[1]
March 2009 - February 2010

Region 3

	Non-Emergency Ambulatory Sedan/Van Trips	Non-Emergency Ambulance/BLS (Broker Sponsored)	Wheelchair Trips	Stretcher Trips	Individual Transportation Gas Trip	Public Transportation Bus Trip	Extra Passenger	All Trip Types
SFY 2008 Trips	192,942	666	32,872	4,104	4,009	0	0	234,593
Miles per Trip	11.2	9.8	14.4	10.8	46.9	0.0	0.0	12.3
SFY 2008 Miles	2,168,285	6,548	471,943	44,365	188,152	0	0	2,879,293
SFY 2008 Costs								
per Mile	1.53	12.07	1.88	11.67	0.38	0.00	0.00	$1.69
Total	3,315,286	79,038	885,822	517,677	70,628	0	0	$4,868,450
Non-claim system payments								$89,928.25
Total payments								$4,958,378.61
SFY 2008 Member Months								1,093,974
SFY 2008 Annual Trips per 1,000 Members								**2,573**
PMPM Cost								**$4.53**
Unit Cost Trend (SFY 2008 to March 2009 - February 2010)								0.960
Utilization Trend (SFY 2008 to March 2009 - February 2010)								
Low (3% annual rate)								1.050
High (5% annual rate)								1.085
Managed Care Savings								
Low (3% savings)								0.970
High (0% savings)								1.000
Administration Allowance								
Low (12% of costs)								1.136
High (18% of costs)								1.220
March 2009 - February 2010 Capitation Rate Range								
Low								**$5.04**
High								**$5.76**

[1] **Region 3 encounter data does not include new populations.**

Exhibit 1
South Carolina Department of Health and Human Services
Non-Emergency Transportation Capitation Rate Range Calculation
Includes New Populations Active During Encounter Data Period [1]
March 2009 - February 2010

Region 4

	Non-Emergency Ambulatory Sedan/Van Trips	Non-Emergency Ambulance/BLS (Broker Sponsored)	Wheelchair Trips	Stretcher Trips	Individual Transportation Gas Trip	Public Transportation Bus Trip	Extra Passenger	All Trip Types
SFY 2008 Trips	205,824	934	40,226	5,159	9,825	0	0	261,968
Miles per Trip	14.0	14.4	13.5	16.1	97.4	0.0	0.0	17.1
SFY 2008 Miles	2,677,744	13,442	542,192	83,281	956,987	0	0	4,473,646
SFY 2008 Costs								
per Mile	1.76	9.65	2.48	8.54	0.39	0.00	0.00	$1.70
Total	5,052,557	129,667	1,342,597	710,958	374,540	0	0	$7,610,320
Non-claim system payments								$140,575.08
Total payments								$7,750,895.30
SFY 2008 Member Months								1,167,885
SFY 2008 Annual Trips per 1,000 Members								**2,692**
PMPM Cost								**$6.64**
Unit Cost Trend (SFY 2008 to March 2009 - February 2010)								0.960
Utilization Trend (SFY 2008 to March 2009 - February 2010)								
Low (3% annual rate)								1.050
High (5% annual rate)								1.085
Managed Care Savings								
Low (3% savings)								0.970
High (0% savings)								1.000
Administration Allowance								
Low (12% of costs)								1.136
High (18% of costs)								1.220
March 2009 - February 2010 Capitation Rate Range								
Low								**$7.38**
High								**$8.43**

[1] **Region 4 encounter data does not include new populations.**

Exhibit 1
South Carolina Department of Health and Human Services
Non-Emergency Transportation Capitation Rate Range Calculation
Includes New Populations Active During Encounter Data Period [1]
March 2009 - February 2010

Region 5

	Non-Emergency Ambulatory Sedan/Van Trips	Non-Emergency Ambulance/BLS (Broker Sponsored)	Wheelchair Trips	Stretcher Trips	Individual Transportation Gas Trip	Public Transportation Bus Trip	Extra Passenger	All Trip Types
SFY 2008 Trips	257,189	571	55,707	6,930	33,558	0	0	353,955
Miles per Trip	11.9	16.0	14.9	15.6	68.6	0.0	0.0	17.6
SFY 2008 Miles	3,064,083	9,135	829,152	108,038	2,303,694	0	0	6,314,102
SFY 2008 Costs								
per Mile	1.66	8.29	2.21	8.35	0.40	0.00	0.00	$1.40
Total	5,095,680	75,761	1,832,741	901,882	911,653	0	0	$8,817,716
Non-claim system payments								$162,877.66
Total payments								$8,980,593.98
SFY 2008 Member Months								1,540,742
SFY 2008 Annual Trips per 1,000 Members								**2,767**
PMPM Cost								**$5.83**
Unit Cost Trend (SFY 2008 to March 2009 - February 2010)								0.960
Utilization Trend (SFY 2008 to March 2009 - February 2010)								
Low (3% annual rate)								1.050
High (5% annual rate)								1.085
Managed Care Savings								
Low (3% savings)								0.970
High (0% savings)								1.000
Administration Allowance								
Low (12% of costs)								1.136
High (18% of costs)								1.220
March 2009 - February 2010 Capitation Rate Range								
Low								**$6.48**
High								**$7.40**

[1] Region 5 encounter data includes trips for Willowglen.

Exhibit 1
South Carolina Department of Health and Human Services
Non-Emergency Transportation Capitation Rate Range Calculation
Includes New Populations Active During Encounter Data Period [1]
March 2009 - February 2010

Region 6

	Non-Emergency Ambulatory Sedan/Van Trips	Non-Emergency Ambulance/BLS (Broker Sponsored)	Wheelchair Trips	Stretcher Trips	Individual Transportation Gas Trip	Public Transportation Bus Trip	Extra Passenger	All Trip Types
SFY 2008 Trips	216,053	292	42,468	2,388	9,060	0	0	270,261
Miles per Trip	13.8	17.1	15.4	18.4	79.8	0.0	0.0	16.3
SFY 2008 Miles	2,983,415	4,984	653,861	43,941	722,905	0	0	4,409,106
SFY 2008 Costs								
per Mile	1.87	9.10	2.27	7.48	0.40	0.00	0.00	$1.75
Total	5,576,170	45,336	1,485,942	328,753	285,761	0	0	$7,721,962
Non-claim system payments								$142,637.29
Total payments								$7,864,599.56
SFY 2008 Member Months								1,264,346
SFY 2008 Annual Trips per 1,000 Members								**2,565**
PMPM Cost								**$6.22**
Unit Cost Trend (SFY 2008 to March 2009 - February 2010)								0.960
Utilization Trend (SFY 2008 to March 2009 - February 2010)								
Low (3% annual rate)								1.050
High (5% annual rate)								1.085
Managed Care Savings								
Low (3% savings)								0.970
High (0% savings)								1.000
Administration Allowance								
Low (12% of costs)								1.136
High (18% of costs)								1.220
March 2009 - February 2010 Capitation Rate Range								
Low								**$6.92**
High								**$7.90**

[1] Region 6 encounter data does not include new populations.

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Exhibit 2

Exhibit 2A
South Carolina Department of Health and Human Services
Non-Emergency Transportation Capitation Rate Calculation for New Populations
March 2009 - February 2010

	Meyer Center	A Child's Haven	Total [1]
SFY 2008 Trips	11,538	22,725	34,263
Miles per Trip	14.3	9.8	11.3
SFY 2008 Miles	165,270	222,795	388,065
October - December 2008 Unit Cost per Mile	$1.43	$1.33	$1.37
Total Reimbursement	$236,336	$296,317	$532,653
SFY 2008 Member Months	891	1,232	2,123
PMPM Service Cost	$265.26	$240.52	$250.90
Unit Cost Trend to March 2009 - February 2010			0.989
Utilization Trend (SFY 2008 to March 2009 - February 2010) Best Estimate (4% annual rate)			1.068
Managed Care Savings Best Estimate (10% savings)			0.900
Incremental Administration Allowance Best Estimate (5% of revenue)			1.053
March 2009 - February 2010 Capitation Rate			$250.87

[1] Total used for Meyer Center, A Child's Haven, and Medically Fragile Children program transportation costs.

Exhibit 2B
South Carolina Department of Health and Human Services
Non-Emergency Transportation Capitation Rate Calculation for New Populations
March 2009 - February 2010

	Regions 1 and 2 Adult Day Center Stretcher Trip (Per Eligible Per Month)		Regions 3 through 6 Adult Day Center Stretcher Trip (Per Eligible Per Month)
Annual Trips per Eligible (10 trips per week, 52 weeks per year)	520	Annual Trips per Eligible (10 trips per week, 52 weeks per year)	520
April - June 2009 Encounter Data Cost per Stretcher Trip	$81.58	SFY 2008 Encounter Data Cost per Stretcher Trip	$132.35
Annual Cost per Eligible	$42,424	Annual Cost per Eligible	$68,824
Member Months per Eligible	12	Member Months per Eligible	12
PMPM Service Cost	**$3,535**	**PMPM Service Cost**	**$5,735**
Unit Cost Trend to March 2009 - February 2010	1.018	Unit Cost Trend to March 2009 - February 2010	0.960
Incremental Administration Allowance Best Estimate (5% of revenue)	1.053	Incremental Administration Allowance Best Estimate (5% of revenue)	1.053
March 2009 - February 2010 Capitation Rate	**$3,788.37**	**March 2009 - February 2010 Capitation Rate**	**$5,797.89**

Exhibit 2C
South Carolina Department of Health and Human Services
Non-Emergency Transportation Capitation Rate Calculation for New Populations
March 2009 - February 2010

	SCDMH	Will Lou Gray		Willowglen		School District of Pickens County
SFY 2006 Trips	57,280	112	SFY 2007 Trips	1,948	SFY 2006 Trips	2,530
Miles per Trip	19.3	17.7	Miles per Trip	39.8	Miles per Trip	12.4
SFY 2006 Miles	1,104,994	1,985	SFY 2007 Miles	77,106	SFY 2006 Miles	31,270
SFY 2006 Unit Cost per Mile	$0.77	$1.90	SFY 2007 Unit Cost per Mile	$0.61	SFY 2006 Unit Cost per Mile	$1.31
Total Reimbursement	$850,845	$3,772	Total Reimbursement	$47,035	Total Reimbursement	$40,964
SFY Eligibles	440	29	SFY Eligibles	141	SFY Eligibles	59
Member Months per Eligible	11	11	Member Months per Eligible	11	Member Months per Eligible	11
SFY 2006 Member Months	4,840	319	SFY 2007 Member Months	1,551	SFY 2006 Member Months	649
PMPM Service Cost	**$175.79**	**$11.82**	**PMPM Service Cost**	**$30.33**	**PMPM Service Cost**	**$63.12**
Unit Cost Trend to March 2009 - February 2010	0.960	0.960	Unit Cost Trend to March 2009 - February 2010	1.028	Unit Cost Trend to March 2009 - February 2010	1.054
Utilization Trend (SFY 2006 to March 2009 - February 2010)			Utilization Trend (SFY 2007 to March 2009 - February 2010)		Utilization Trend (SFY 2006 to March 2009 - February 2010)	
Best Estimate (4% annual rate)	1.066	1.066	Best Estimate (4% annual rate)	1.110	Best Estimate (4% annual rate)	1.155
Managed Care Savings			Managed Care Savings		Managed Care Savings	
Best Estimate (10% savings)	0.900	0.900	Best Estimate (10% savings)	0.900	Best Estimate (10% savings)	0.900
Incremental Administration Allowance			Incremental Administration Allowance		Incremental Administration Allowance	
Best Estimate (5% of revenue)	1.053	1.053	Best Estimate (5% of revenue)	1.053	Best Estimate (5% of revenue)	1.053
March 2009 - February 2010 Capitation Rate	**$170.74**	**$11.48**	**March 2009 - February 2010 Capitation Rate**	**$32.79**	**March 2009 - February 2010 Capitation Rate**	**$72.80**

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Exhibit 3

Exhibit 3
South Carolina Department of Health and Human Services
Non-Emergency Transportation Add-on Revenue / Capitation Rates for New Populations by Region
March 2009 - February 2010

	MTM		LogistiCare			
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
March 2009 - February 2010 Capitation Rate for New Populations						
Meyer Center	$250.87		$250.87			
A Child's Haven	$250.87		$250.87			
Medically Fragile Children	$250.87		$250.87			
Adult Day Center Stretcher Trips	$3,788.37		$5,797.59			
South Carolina Department of Mental Health	$170.74		$170.74			
Wil Lou Gray School	$11.48		$11.48			
School District of Pickens	$72.80		$72.80			
Willowglen	$32.78		$32.78			
Member Months for New Populations (Included in Encounter Data)						
Meyer Center	891	0	0	0	0	0
A Child's Haven	1,232	0	0	0	0	0
Medically Fragile Children	600	0	0	0	0	0
Adult Day Center Stretcher Trips	24	24	0	0	0	0
South Carolina Department of Mental Health	0	0	0	0	0	0
Wil Lou Gray School	0	0	0	0	0	0
School District of Pickens	649	0	0	0	0	0
Willowglen	0	0	0	0	1,551	0
Total	3,396	24	0	0	1,551	0
Revenue to Add to Year 4 Broker Proposal Revenue	$821,295	$60,921	$0	$0	$50,844	$0
Member Months for New Populations (Excluded from Encounter Data)						
Meyer Center	0	0	0	0	0	0
A Child's Haven	0	0	0	0	0	0
Medically Fragile Children	0	0	1,800	0	0	240
Adult Day Center Stretcher Trips	0	0	24	24	24	24
South Carolina Department of Mental Health	0	0	3,388	1,452	0	0
Wil Lou Gray School	0	0	319	0	0	0
School District of Pickens	0	0	0	0	0	0
Willowglen	0	0	0	0	0	0
Total	0	0	5,531	1,476	24	264
Total March 2009 - February 2010 Revenue for New Populations	$0	$0	$1,172,831	$387,051	$139,142	$199,362
Projected March 2009 - February 2010 Member Months			1,154,259	1,206,014	1,592,419	1,313,694
PMPM Add-on Capitation for New Populations			$1.02	$0.32	$0.09	$0.15

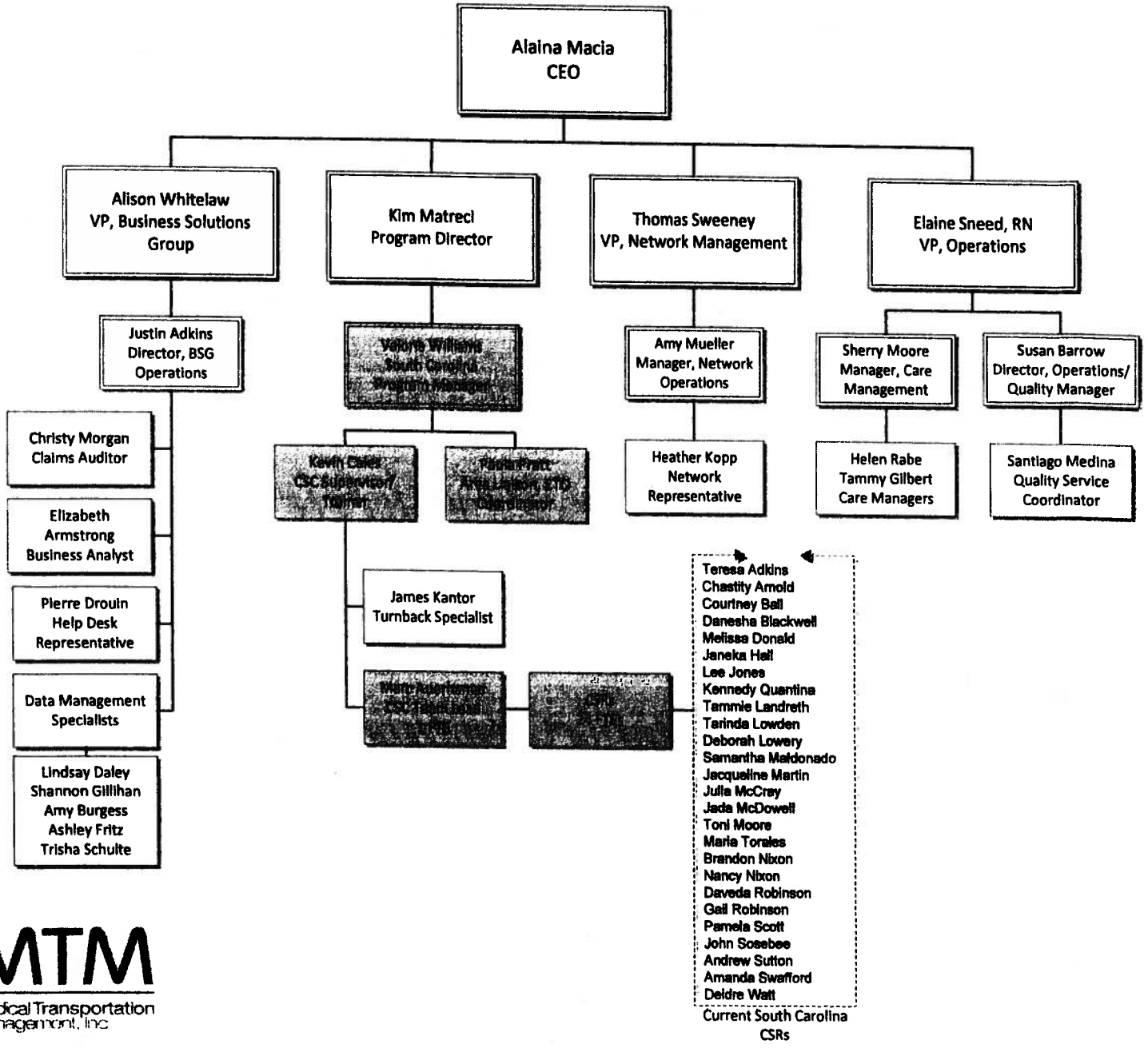
South Carolina Medicaid NEMT Program
Cost of Program based upon Actuarial Study Trended Forward
Comparison to Bid Cost as Submitted

NEMT Region	Actuarial Study Trended Forward Initital 3 Year Contract Period			Bids as Submitted Initital 3 Year Contract Period		
	Low	Mid	High	MTM	LC	AMR
1	$ 41,022,378	$ 47,446,606	$ 53,743,707	$ 43,657,276	$ 39,892,608	
2	$ 65,813,836	$ 76,007,388	$ 87,288,278	$ 66,556,591		$ 46,264,005
3	$ 70,121,790	$ 81,152,959	$ 93,695,874	$ 81,903,270		$ 46,581,911

	Option Year 1			Option Year 1		
	Low	Mid	High	MTM	LC	AMR
1	$ 17,182,174	$ 20,891,476	$ 24,673,747	$ 18,598,797	$ 15,824,981	
2	$ 27,314,976	$ 33,067,891	$ 39,714,187	$ 28,186,763		$ 17,021,950
3	$ 28,974,201	$ 35,128,243	$ 42,446,255	$ 35,211,951		$ 17,138,917

	Option Year 2			Option Year 2		
	Low	Mid	High	MTM	LC	AMR
1	$ 18,469,836	$ 23,067,389	$ 27,873,740	$ 20,456,396	$ 16,889,837	
2	$ 29,235,805	$ 36,301,974	$ 44,671,379	$ 30,923,680		$ 17,475,308
3	$ 30,945,153	$ 38,467,857	$ 47,643,149	$ 38,950,912		$ 17,595,386

Local Organization Chart



MTM
Medical Transportation Management, Inc

BRUNER, POWELL, WALL & MULLINS, LLC

ATTORNEYS AND COUNSELORS AT LAW
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POST OFFICE BOX 61110
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WESLEY D. PEEL, P.A.

JOEY R. FLOYD, P.A.
WILLIAM D. BRITT, JR., P.A.

LEAH EDWARDS GARLAND
BENJAMIN C. BRUNER
MATTHEW H. STABLER

* Also Admitted in District of Columbia

AUTHOR'S E-MAIL: WMULLINS@brunerpowell.com

December 20, 2010

VIA ELECTRONIC AND HAND DELIVERY:
Voight Shealy
Chief Procurement Officer
Materials Management Office
1201 Main Street
Columbia, SC 29201

RE: Supplemental Protest of Notice of Intent to Award
Solicitation: 5400002201 (Non-Emergency Medical Transportation Services)
Contract No.: 4400003143 (Logisticare Solutions, LLC)
Contract No.: 4400003144 (American Medical Response, Inc.)
Our File No. 7-1628.108

Dear Mr. Shealy:

This firm has been asked to assist Medical Transportation Management, Inc. ("MTM") in connection with the above referenced solicitation. MTM, through its General Counsel Donald C. Tiemeyer, timely filed a protest in connection with the solicitation and intent to award Contract No. 4400003143 to Logisticare Solutions, LLC ("Logisticare") for Region 1 and Contract No. 4400003144 to American Medical Response, Inc. for Regions 2 and 3 for Non-Emergency Medical Transportation Services ("NEMT"). Pursuant to S.C. Code Ann. § 11-35-4210, MTM hereby supplements its protest filed on December 10, 2010. MTM reiterates and incorporates by reference its protest grounds set forth in the protest letter of December 10, 2010. MTM would assert the following factual and legal basis for protest in addition to those grounds set forth in the protest letter of December 10, 2010:

1. Significant change in Medicaid Services.

This solicitation involves an RFP to obtain contract services for non-emergency medicaid transportation for three identified Regions of the State. The following question and answer was contained in Amendment # 1:

> 8. Are any benefit changes anticipated or under consideration that may impact utilization under this program?

Answer: SCDHHS is expecting to add the Healthy Connections Kids (HCK) population of approximately 16,000 children in the fourth quarter of calendar year 2010. However, this population currently provides its own transportation and the agency does not anticipate significant utilization of the transportation program. At this point, no additional programs are anticipated.

As such through Amendment #1 issued on October 3, 2010, the State informed all potential bidders that no benefit changes were forthcoming that could impact utilization of the program. However, on December 14, 2010, the Department of Health and Human Services ("DHHS") issued a Medicaid Bulletin announcing a drastic reduction in optional State Medicaid Services. **See Exhibit A.** The significant reduction in services announced through the Medicaid Bulletin would have a substantial impact on the pricing offered by bidders in the above-referenced solicitation. Had bidders been informed of these impending eliminations, the State would have saved millions of dollars over the life of this contracts.

Under this solicitation, the Offerors were required to determine a per member per month price for transportation costs and then calculate a fixed annual transportation cost to the State. While MTM understood that the service volumes in the RFP were just estimates, it relied on those volumes in the calculation of its proposed pricing. MTM and, upon information and belief the other Offerors, were not made aware of the forthcoming substantial reduction in services and were in fact assured no benefit changes were forthcoming. If the award of this solicitation were allowed to stand at the awarded amount, the State will be paying a fixed annual rate based on a volume of services that cannot and will not happen due to the recent Medicaid Bulletin. Thus, if the State goes forward with this intent to award, it will be overpaying for such services by millions of dollars. In these times of budget shortfalls, it is unconscionable to think that proceeding with these awards would be in the best interest of the State. Based on this change of true requirements which the Offerors were not informed of, but which was announced just after the intent to award was issued, the CPO has the authority under the Procurement Code and Regulations to, and most certainly should, exercise his authority to cancel the intent to award and solicitation and re-issue a new solicitation based on the new requirements. Such action would immediately result in millions of dollars of savings to the State and would avoid an inappropriate windfall to any vendor.

2. AMR is a non-responsive and/or non-responsible bidder.

AMR improperly included pricing information in its technical proposal. Thus, its proposal was non-responsive. It appears that the State may have modified AMR's technical proposal to remove pricing information. In addition to it being impermissible for the State to modify a non-responsive proposal to make it responsive, the removal of the pricing information made AMR's proposal non-responsive because, with the pricing information removed, AMR failed to provide any response. As such, AMR's proposal should have been rejected as non-responsive.

AMR's proposal contained material misrepresentations that necessarily created the opportunity for improper influence over the evaluation of the proposals. Attached is a page from the AMR proposal for SC Region 3. ***See*** **Exhibit B.** The top of the page is described as a sample of a facility postcard used during implementation. The sample is completely false and misleading. AMR did not win an award in Wisconsin. In fact, LogistiCare was initially awarded the Wisconsin NEMT contract; however, that award has subsequently been cancelled. This "sample postcard" is a blatant attempt to mislead the evaluators. Here, AMR had the ability to attach any sample, but chose to create a false sample to imply to South Carolina that AMR had won a contract that it did not win.

Additionally, AMR's proposed software for trip scheduling, Access2Care or A2C, is, upon information and belief, currently unreliable for large transportation programs such as the proposed awards of Regions 2 and 3; is unable to handle high volumes of trips, and is dropping or losing trip assignments that should be referred to transportation providers. Upon information and belief, the problems with this software were causing implementation problems in Idaho before AMR submitted its proposal in response to the above-referenced solicitation, and the software problems have yet to be fixed. Thus, in responding to this solicitation, AMR intentionally misrepresented the abilities and reliability of its A2C software system.

Misrepresentation is a matter of good faith. It has been repeatedly held that where a misrepresentation is made in bad faith or materially influences a determination or evaluation, the proposal should be rejected. See, e.g., *In Re: Protest of PS Energy*, Case No. 2002-9.

MTM will rely on these arguments, the arguments set forth in its protest letter of December 10, 2010 and such additional information as may become available through the course of the Freedom of Information Act requests and further investigation. We look forward to the administrative review and hearing of this protest and presenting our proof.

With my kindest regards, I am

Very truly yours,

E. Wade Mullins III

JES:dea
cc: Donald C. Tiemeyer, Esq.
John Schmidt, Esq.
Keith McCook, Esq.
Molly Crum, Esq.

A

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.scdhhs.gov

December 14, 2010

ALL

MEDICAID BULLETIN

To: **Medicaid Providers**

Subject: **Medicaid Reductions**

The South Carolina Department of Health and Human Services (SCDHHS) projects a budget shortfall of $228 million during the current fiscal year. This is a result of a combination of significant enrollment increases and budget reductions. In order to safeguard the financial viability of the Medicaid program and meet statutory requirements for the operation of Medicaid, SCDHHS must take prompt action to contain Medicaid costs. Current state and federal restrictions largely limit the agency's ability to make reductions apart from reducing optional state Medicaid services.

Below is a list of upcoming changes. Additional Medicaid Bulletins may be issued to provide further details. To learn more about South Carolina's Medicaid budget, current restrictions and to offer cost-saving suggestions, please visit http://msp.scdhhs.gov/msp.

INDEX:

1. **The following eliminations are effective for dates of service on or after February 1, 2011:**

- **Discontinue Coverage of Podiatry services for adults**
  SCDHHS will discontinue coverage of Podiatric services for beneficiaries over the age of 21.

- **Discontinue Coverage of Vision services for adults**
  SCDHHS will discontinue coverage of Vision services for beneficiaries over the age of 21. Those services affected by this change include routine eye exams and refraction as well as glasses that fall within the policy limitation. Medically necessary vision services will continue to be covered. Payment of these services are subject to review by the SCDHHS Program Integrity Division.

- **Discontinue Coverage of Dental services for adults**
  Dental services currently covered under the State Plan for beneficiaries aged 21 or older will no longer be covered, regardless of setting.

- **Discontinue Coverage of Hospice care services for adults**

- **Discontinue Coverage of routine newborn circumcisions**
  SCDHHS will no longer cover routine newborn circumcisions. Medically necessary circumcisions will continue to be covered for all male beneficiaries but must receive prior approval. For additional information on this policy update, please refer to the Physicians, Laboratories, and Other Medical Professionals Manual. The most current versions of the provider manuals are maintained on the SCDHHS website at www.scdhhs.gov.

- **Discontinue Coverage for Insulin Pumps for Type II Diabetics**
  SCDHHS will only cover Insulin pumps for Type I Diabetics. For additional information on this policy update, please refer to the Durable Medical Equipment Manual. The most current versions of the provider manuals are maintained on the SCDHHS website at www.scdhhs.gov.

- **Discontinue Coverage of Syvek patch**

- **Discontinue Coverage of wheelchair accessories such as umbrella holder, pillows and crutch/cane holder**
  SCDHHS will discontinue coverage of all non-medically necessary wheelchair accessories which include but are not limited to crutch/cane holders, umbrella holder, and similar accessories.

2. **The following reductions are effective for dates of service on or after February 1, 2011:**

- Diabetic shoes will be reduced from two pairs per year to one
- Diabetic shoe inserts will be reduced from six per year to three
- Home health visits will be reduced from 75 visits to 50 visits per year
- Individuals under 21 years of age can only receive a combined total of 75 visits per year for private rehabilitative services (speech and language therapy, occupational therapy or physical therapy)
- Chiropractic services will be reduced from eight visits to six visits per year
- Adult pharmacy overrides will be reduced from four per month to three
- Power wheelchairs will be replaced every seven years instead of five
- Adult behavioral health services will be limited to 12 outpatient visits per year

3. **The following service eliminations for the Community Long Term Care (CLTC) Program are effective for dates of service on or after April 1, 2011:**

   - Chore service
   - Appliance service
   - Nutritional supplements
   - Adult day health care nursing service
   - Respite service

4. **The following service reduction for the Community Long Term Care (CLTC) Program is effective for dates of service on or after April 1, 2011:**

   - Home delivered meals will be reduced from 14 to 10 meals per week

5. **Increase in Co-Payments Effective for dates of service on or after April 1, 2011:**

   Beginning April 1, 2011, SCDHHS will increase co-pays for certain visits. However, the following categories are exempt from co-pays:

   - Children under 19 years of age
   - Pregnant women
   - Individuals receiving Family Planning services
   - Institutionalized individuals
   - Individuals receiving emergency services
   - Federally-recognized Native Americans

   All other Medicaid beneficiaries will be subject to the following changes:

	Old	New
• Office Visits (Physician, Nurse Practitioner, Licensed Midwife)	$2.00	$2.30
• Chiropractor	$1.00	$1.15
• Home Health	$2.00	$2.30
• Clinic Visits	$2.00	$2.30
• Prescription Drugs	$3.00	$3.40
• Outpatient Hospital	$3.00	$3.40
• Non-Emergent Services in the Emergency Room	$3.00	$3.40
• Medical Equipment and Supplies (co-pay will vary)	$0-3.00	$.60-$3.40

If you have any questions regarding this bulletin or any other Medicaid billing or policy questions, please contact your provider representative. Thank you for your continued support and participation in the South Carolina Medicaid Program.

/s/

Emma Forkner
Director

NOTE: To receive Medicaid bulletins by email, please register at http://bulletin.scdhhs.gov/.
To sign up for Electronic funds Transfer of your Medicaid payment, please go to: http://www.dhhs.state.sc.us/dhhsnew/hipaa/index.asp and select "Electronic funds Transfer (EFT)" for instructions.

B

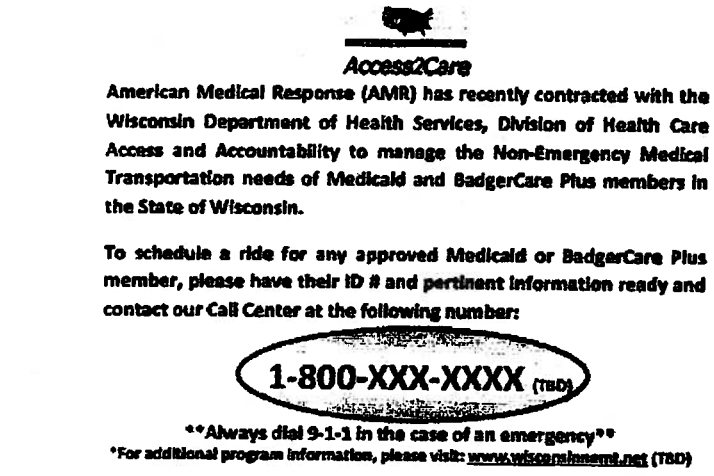


Figure 16 Sample Facility postcard used during implementation

In addition, the Case Manager will contact, by telephone or in person, large medical facilities, dialysis centers and skilled nursing facilities to confirm receipt of the card as well as answer any questions or concerns.

Furthermore, AMR will work closely with the medical provider community to ensure that the following topics are known and understood:

- That NEMT services are available
- How to schedule and use NEMT services
- Where to call when there is a problem
- How to use the medical provider Web portal

In order to disseminate information about these topics, AMR will conduct periodic training sessions across the State and / or via webinar. In addition, we will do additional outreach to the larger hospital and dialysis facilities by offering in-house training sessions at those facilities It is our experience that these facilities are the largest users of NEMT services and knowledge on availability of services, availability of the medical provider Web portal, and efficiency in scheduling techniques allows for a much higher level of service to the members.

SCHMIDT & COPELAND LLC
Attorneys and Counselors at Law

John E. Schmidt, III
803.348.2984
John.Schmidt@TheSCLawfirm.com

December 13, 2010

Via Email to vshealy@mmo.sc.gov

Mr. Voight Shealy
Chief Procurement Officer for Goods and Services
Material Management Office
1201 Main Street, Suite 600
Columbia, South Carolina 29201

RE: Protest of Notice of Intent to Award to American Medical Response Inc., Contract Number 4400003144
Solicitation: 5400002201
Description: Non-Emergency Medical Transportation Bid

Dear Mr. Shealy:

This firm represents Logisticare Solutions, LLC ("Logisticare") in connection with the above matter. Logisticare hereby protests the notice of intent to award a contract or contracts for Region 2 and Region 3 in connection with the above procurement to American Medical Response Inc., ("AMR"), which notice indicates that it was posted December 14, 2010, but which, on information and belief, was actually posted on and not before December 3, 2010. The grounds of this protest are set forth below.

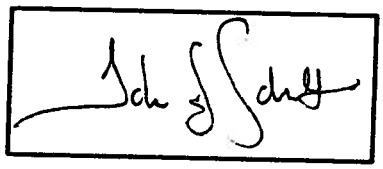
This procurement involves an RFP to obtain contract services for certain medical transportation for various Regions of the State. This protest addresses only the awards to AMR as to Regions 2 and 3. Award for these two Regions was to be made to the highest scored, responsive and responsible offeror. Logisticare was the second highest scoring offeror as to these two Regions overall, and was, as will be shown below, the highest scored responsive and responsible offeror.

Logisticare protests the notice of intent to award contracts for Regions 2 and 3 to AMR because AMR is not a Responsible or Responsive Offeror because it wrongly and knowingly included pricing information and details from its Separately sealed Price Proposal in its separately sealed Technical Proposal. The inclusion of pricing information is contrary to the RFP, to long-

established and well-recognized procurement practices and guidelines in the State of South Carolina. AMR purposefully included such detailed pricing information in its Technical proposal, when it knew fully that such was not to be included. Thus, AMR's proposal was submitted in violation of the rules for submission of proposals, cannot be "cured" by any action of the state, and must be stricken, and the awards to AMR must be cancelled, and the contracts at issue should be awarded directly to the second highest scored offeror, Logisticare, a responsible offeror whose offer is fully responsive. The state should not be bound to resolicit in such a case where the vendor that was initially chosen must be disqualified due to material non-compliance. Alternatively, the states requirements for Regions 2 and 3 should be resolicited.

Wherefore, Logisticare requests a hearing and reaward to the contracts at issue to it, or, in the alternative, that the states requirements as to Regions 2 and 3 be resolicited.

Sincerely yours,



John E. Schmidt, III

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SCHMIDT & COPELAND LLC
Attorneys and Counselors at Law

John E. Schmidt, III
803.348.2984
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Melissa J. Copeland
803.309.4686
Missy.Copeland@TheSCLawfirm.com

December 17, 2010

Via Email to vshealy@mmo.sc.gov

Mr. Voight Shealy
Chief Procurement Officer for Goods and Services
Material Management Office
1201 Main Street, Suite 600
Columbia, South Carolina 29201

RE: **AMENDED** Protest of Notice of Intent to Award to American Medical Response Inc., Contract Number 4400003144
Solicitation: 5400002201
Description: Non-Emergency Medical Transportation Bid

Dear Mr. Shealy:

This firm represents Logisticare Solutions, LLC ("Logisticare") in connection with the above matter and provides this amended protest of the notice of intent to award a contract or contracts for Region 2 and Region 3 in connection with the above procurement to American Medical Response Inc., ("AMR"). The amended grounds of this protest are set forth below.

1. **Significant change in Medicaid Services**.

This procurement involves an RFP to obtain contract services for certain medical transportation for various Regions of the State. The following question and answer was contained in Amendment # 1:

> 8. Are any benefit changes anticipated or under consideration that may impact utilization under this program?
>
> **Answer: SCDHHS is expecting to add the Healthy Connections Kids (HCK) population of approximately 16,000 children in the fourth quarter of calendar year 2010. However, this population currently provides its own transportation and the agency does not anticipate significant utilization of the transportation program. At this point, no additional programs are anticipated.**

Although as shown above on October 3, 2010, the State informed all potential bidders that no benefit changes were forthcoming, on December 14, 2010, the Department of Health and Human Services issued a Medicaid Bulletin announcing a drastic reduction in optional State Medicaid Services. See Attachment 1. This Medicaid Bulletin's announced cuts in services have a substantial impact on the pricing offered by bidders in the above-referenced solicitation. Had bidders been informed of these impending eliminations, the State would have saved millions of dollars over the life of this contract.

Under this solicitation, bidders were required to determine a per member per month price for transportation costs and then calculate a fixed annual transportation cost to the State. Bidders understood that the provided estimates of service volume were just an estimate. However, bidders were not made aware of the forthcoming substantial reduction in services and were in fact assured no benefit changes were forthcoming[1]. If the award of this solicitation were allowed to stand at the awarded amount, the State will be paying a fixed annual rate based on a volume of services that cannot and will not happen due to the recent Medicaid Bulletin. Thus, the State goes forward with this intent to award, it will be overpaying by millions of dollars. Based on this change of true requirements which vendors were not informed of, but which was announced just after the intent to award was issued, the CPO has the authority under the Procurement Code and Regulations to, and most certainly should, exercise his authority to cancel the intent to award and solicitation and re-issue a new solicitation based on the new requirements.

2. AMR is a non-responsive and/or non-responsible bidder.

AMR improperly included pricing information in its technical proposal. Thus, its proposal was non-responsive. It appears that the State may have modified AMR's technical proposal to remove pricing information. In addition to it being impermissible for the State to modify a non-responsive proposal to make it responsive, the removal of the pricing information made AMR's proposal non-responsive because with the pricing information removed, AMR failed to provide any response.

Attached is a page from the AMR proposal for SC Region 3. *See* Attachment 2. The top of the page is described as a sample of a facility postcard used during implementation. The sample is completely false and misleading. AMR did not win an award in Wisconsin. In fact, LogistiCare was awarded the entire state of Wisconsin NEMT contract. This "sample postcard" is a blatant attempt to mislead the evaluators. Here, AMR had the ability to attach any sample, but chose to

[1] Medical Transportation Management, Inc. submitted a protest detailing that AMR's Bid is around 24 million less than the lowest actuarially sound rate. Such an excessively low bid could only make sense if AMR was somehow aware of the impending changes announced by the December 14 Medicaid Bulletin, which the State in Amendment 1 disavowed were coming and of which no other bidders were aware.

create a false sample to imply to South Carolina that AMR had won a contract than it did not win.

Additionally, AMR's proposed software for trip scheduling, Access2Care or A2C, is, upon information and belief, currently unreliable for large transportation programs such as the proposed awards of Regions 2 and 3; is unable to handle high volumes of trips, and is dropping or losing trip assignments that should be referred to transportation providers. Upon information and belief, these problems with this software were causing implementation problems in Idaho before AMR submitted its proposal in response to the above-referenced solicitation, and the software problems have yet to be fixed. Thus, in responding to this solicitation, AMR intentionally misrepresented the abilities and reliability of its A2C software system.

Misrepresentation is a matter of good faith. Where a misrepresentation is made in bad faith or materially influences a determination or evaluation, the proposal should be rejected. *In Re: Protest of PS Energy*, Case No. 2002-9.

CONCLUSION

Based on the grounds set forth in Logisticare's original protest as well as this amended protest, Logisticare requests a hearing, cancellation of the intent to award to AMR as to Regions 2 and 3, and re-award to it of the contracts at issue for Regions 2 and 3, or, in the alternative, requests that the CPO declare that in view of the State's changed requirements announced just after issuance of an intent to award, that the intent to award and solicitation be cancelled under governing authority set forth in the Procurement Code and Regulations, and State's new requirements be revised accordingly and resolicited.

Very truly yours,

John E. Schmidt, III

Post Office Box 11547 Columbia, South Carolina 29211
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www.scdhhs.gov

December 14, 2010

ALL

MEDICAID BULLETIN

To: **Medicaid Providers**

Subject: **Medicaid Reductions**

The South Carolina Department of Health and Human Services (SCDHHS) projects a budget shortfall of $228 million during the current fiscal year. This is a result of a combination of significant enrollment increases and budget reductions. In order to safeguard the financial viability of the Medicaid program and meet statutory requirements for the operation of Medicaid, SCDHHS must take prompt action to contain Medicaid costs. Current state and federal restrictions largely limit the agency's ability to make reductions apart from reducing optional state Medicaid services.

Below is a list of upcoming changes. Additional Medicaid Bulletins may be issued to provide further details. To learn more about South Carolina's Medicaid budget, current restrictions and to offer cost-saving suggestions, please visit http://msp.scdhhs.gov/msp.

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   - **Discontinue Coverage of Vision services for adults**
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  Dental services currently covered under the State Plan for beneficiaries aged 21 or older will no longer be covered, regardless of setting.

- **Discontinue Coverage of Hospice care services for adults**

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  SCDHHS will no longer cover routine newborn circumcisions. Medically necessary circumcisions will continue to be covered for all male beneficiaries but must receive prior approval. For additional information on this policy update, please refer to the Physicians, Laboratories, and Other Medical Professionals Manual. The most current versions of the provider manuals are maintained on the SCDHHS website at www.scdhhs.gov.

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  SCDHHS will discontinue coverage of all non-medically necessary wheelchair accessories which include but are not limited to crutch/cane holders, umbrella holder, and similar accessories.

2. **The following reductions are effective for dates of service on or after February 1, 2011:**

- Diabetic shoes will be reduced from two pairs per year to one
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- Home health visits will be reduced from 75 visits to 50 visits per year
- Individuals under 21 years of age can only receive a combined total of 75 visits per year for private rehabilitative services (speech and language therapy, occupational therapy or physical therapy)
- Chiropractic services will be reduced from eight visits to six visits per year
- Adult pharmacy overrides will be reduced from four per month to three
- Power wheelchairs will be replaced every seven years instead of five
- Adult behavioral health services will be limited to 12 outpatient visits per year

3. **The following service eliminations for the Community Long Term Care (CLTC) Program are effective for dates of service on or after April 1, 2011:**

   - Chore service
   - Appliance service
   - Nutritional supplements
   - Adult day health care nursing service
   - Respite service

4. **The following service reduction for the Community Long Term Care (CLTC) Program is effective for dates of service on or after April 1, 2011:**

   - Home delivered meals will be reduced from 14 to 10 meals per week

5. **Increase in Co-Payments Effective for dates of service on or after April 1, 2011:**

   Beginning April 1, 2011, SCDHHS will increase co-pays for certain visits. However, the following categories are exempt from co-pays:

   - Children under 19 years of age
   - Pregnant women
   - Individuals receiving Family Planning services
   - Institutionalized individuals
   - Individuals receiving emergency services
   - Federally-recognized Native Americans

   All other Medicaid beneficiaries will be subject to the following changes:

	Old	New
• Office Visits (Physician, Nurse Practitioner, Licensed Midwife)	$2.00	$2.30
• Chiropractor	$1.00	$1.15
• Home Health	$2.00	$2.30
• Clinic Visits	$2.00	$2.30
• Prescription Drugs	$3.00	$3.40
• Outpatient Hospital	$3.00	$3.40
• Non-Emergent Services in the Emergency Room	$3.00	$3.40
• Medical Equipment and Supplies (co-pay will vary)	$0-3.00	$.60-$3.40

If you have any questions regarding this bulletin or any other Medicaid billing or policy questions, please contact your provider representative. Thank you for your continued support and participation in the South Carolina Medicaid Program.

/s/

Emma Forkner
Director

**NOTE: To receive Medicaid bulletins by email, please register at http://bulletin.scdhhs.gov/.
To sign up for Electronic funds Transfer of your Medicaid payment, please go to:
http://www.dhhs.state.sc.us/dhhsnew/hipaa/index.asp and select "Electronic funds Transfer (EFT)" for instructions.**

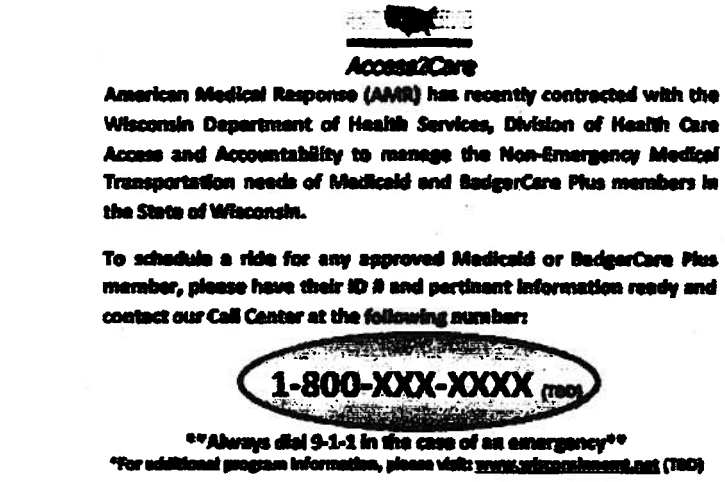

Figure 16 Sample Facility postcard used during implementation

In addition, the Case Manager will contact, by telephone or in person, large medical facilities, dialysis centers and skilled nursing facilities to confirm receipt of the card as well as answer any questions or concerns.

Furthermore, AMR will work closely with the medical provider community to ensure that the following topics are known and understood:

- That NEMT services are available
- How to schedule and use NEMT services
- Where to call when there is a problem
- How to use the medical provider Web portal

In order to disseminate information about these topics, AMR will conduct periodic training sessions across the State and / or via webinar. In addition, we will do additional outreach to the larger hospital and dialysis facilities by offering in-house training sessions at those facilities It is our experience that these facilities are the largest users of NEMT services and knowledge on availability of services, availability of the medical provider Web portal, and efficiency in scheduling techniques allows for a much higher level of service to the members.

-----Original Message-----
From: Novit, Adrian [mailto:novit@musc.edu]
Sent: Tuesday, December 14, 2010 10:18 AM
To: Covey, Daniel
Subject: Urgent- FW: Protest- solicitation#5400002201

Dear Mr. Covey,
Please see the attached email below. Unfortunately I sent this email to the wrong email address last night (I misspelled your name). I hope this letter isn't too late for the protest deadline.
Thank you for your time in this matter.

Adrian Novit, PhD
Program Coordinator/Clinical Psychologist MUSC STAR Children's Day Treatment Program
3495 Iron Horse Dr
Ladson, SC 29456
Phone: 843-875-8510
Fax: 843-875-8523

-----Original Message-----
From: Novit, Adrian [mailto:novit@musc.edu]
Sent: Monday, December 13, 2010 4:29 PM
To: 'dkovey@mmo.sc.gov'
Subject: Protest- solicitation#5400002201

Dear Mr. Kovey,
I just received word that our current nonemergency medical transportation broker (Logisticare-solicitation #5400002201) will no longer be our broker as of Feb, 2011. I am writing this protest in an email because I understand the cut-off date for a protest is 12/14/10 and I just found out about this today so there won't be enough time to mail a protest to your office.
It is very distressing to our agency to learn about this because a disruption in brokers will interfere with our continuity of care and we will likely not be able to receive the special services/program that we have been receiving from Logisitcare. Our agency is a Children's Day Treatment Program where clients (ages 4-13yrs) attend our program every day M-F (8:15-3:15) instead of attending regular school because their severe psychiatric issues impede their ability to successfully function in regular school. I worry that if we

lose Logisticare, our program will not succeed because we will no longer have transportation for our clients. Logisticare has worked very closely with our program to provide us with a specially-tailored transportation program where one contractor (DJ's transportation) exclusively provides transportation for our clients (and provides an escort). This particular company was hand-picked by Logisticare because the owner is sensitive to and understands the special needs of our clients. Also, Logisticare has set up a special program for our agency to submit standing orders directly to the Region 6 Manager (Krista Martin) which gets transportation arranged much quicker and smoother than going through facilities assistance and getting a different person every time (and having to explain our program and clients to a different person every time). Without the efforts and assistance of Krista Martin and Logisticare, our agency would have likely shut down last year because we would not have had transportation for our clients to attend our program every day.

I urge you to please reconsider your decision and give the contract back to Logisticare. Our agency and the clients we serve in 4 counties (Charleston, Berkeley, Dorchester, Colleton) will likely have to shut down if we don't have Logisticare helping us with transportation. We provide a vital service to the communities but we need Logisticare to survive and continue providing quality programs.

Thank you for your time. If you have any further questions or comments, I can be reached at this email or you can call me at 843-875-8510.

Sincerely,

Adrian Novit, PhD
Program Coordinator/Clinical Psychologist MUSC STAR Children's Day Treatment Program
3495 Iron Horse Dr
Ladson, SC 29456
Phone: 843-875-8510
Fax: 843-875-8523

From: Sonny Williams [mailto:swill936@yahoo.com]
Sent: Friday, December 10, 2010 4:14 PM
To: Covey, Daniel
Cc: swill936@yahoo.com; alfgold@aol.com
Subject: Intent to award to AMR Broker contract

Dear Sir
I would like to protest the intent to award to AMR. My protest is based on the intent of AMR to locate their office/call center in Columbia SC. Currently Logisticare has their office in Mullins SC. Mullins is located in one of the most impoverished areas of South Carolina and can ill afford to loose the approximately 70 jobs logisticare currently hosts in the area. Allowing AMR to move these jobs and the tax/ecomonic base contained does not make sense in our already difficult economy. If this is not the the proper arena for this protest please advise me of the proper arena so I may get my protest in before the conclusion of the protest period.

Thanks
Sonny Williams
2113 Oakland Rd
Hamer SC 29547
843-774-4800 home
843-430-0573 cell
843-464-2776 work
swill936@yahoo.com

STATE OF SOUTH CAROLINA	)	Before the Chief Procurement Officer
	)	Case Nos. 2010-150, 2010-151, 2010-152,
COUNTY OF RICHLAND	)	and 2010-153
IN THE MATTER OF: Protest IFB No: 5400002201 Statewide Medical Supplies	)	
Logisticare Solutions, LLC CASE NUMBER: 2010-150	)	
Medical Transportation Management, Inc. CASE NUMBER: 2010-151	)	**MOTION TO DISMISS AND MEMORANDUM IN SUPPORT OF MOTION TO DISMISS**
Adrian Novit CASE NUMBER: 2010-152	)	
Sonny Williams CASE NUMBER: 2010-153	)	

This matter arises under the South Carolina Consolidated Procurement Code, S.C. Code Ann. §§ 11-35-110 (Supp. 2010) (Code). American Medical Response, Inc. (AMR) hereby moves to dismiss (1) the protest of Adrian Novit (Novit), (2) the protest of Sonny Williams (Williams), and (3) certain protest grounds of Medical Transportation Management, Inc. (MTM). The protests filed by Novit and Williams both should be dismissed on the ground that they do not have standing to bring a protest and that the Novit protest was not timely filed.

The grounds of the MTM protest discussed below should be dismissed, because they are not timely filed, fail to state a cause of action upon which relief can be granted, and/or because they are overly broad and vague on contravention of the requirements of S.C. Code Ann. § 11-35-4210(2) (Supp. 2009). As such, AMR requests that the CPO grant its Motion and dismiss the protests of Novit and Williams and the identified protest grounds of MTM as a matter of law.

BACKGROUND

On September 9, 2010, MMO issued Solicitation Number 5400002201 (RFP or Solicitation) for non-emergency transportation services for use by the South Carolina Department of Health & Human Services (HHS) Medicaid beneficiaries. The South Carolina Non-Emergency Medical Transportation (NEMT) Program pays for transportation of eligible Medicaid members to medical care or services, which are covered under the Medicaid Program. The NEMT Program is intended to provide non-emergency transportation services in a cost-effective manner to Medicaid members who need access to medical care or services. Federal requirements regarding transportation services are described in 42 CFR §440.170(a)(4). This procurement will result in the award of a separate contract for each of three (3) regions within the state. The purpose of the Solicitation is to procure a qualified broker to improve the efficiency and effectiveness and to administer the core components of the HHS' NEMT Program.

Daniel W. Covey, CPPB, was the procurement officer assigned to this request for proposal. Amendment 1 was issued on October 3, 2010. Amendment 2 was issued on October 11, 2010. Extension of Award Posting #1 was issued in accordance with The Budget and Control Board Regulations, Section 19-445.2090 (B), making the new award posting date November 29, 2010. Than Extension of Award Posting #2 was issued making the new award posting date December 3, 2010.

On December 3, 2010 MMO posted the Intent to Award to AMR for regions 2 and 3 (Contract Number 4400003144) with a December 14, 2010 effective date as noted below:

Total Potential Value: $162,077,477.00
Maximum Contract Period: December 14, 2010 through December 13, 2015

Item	Description	Unit Price
00004	Medical Trans Reg 2 years 1 through 3	$ 46,264,005.00
00005	Medical Trans Reg 2 Optional year 1	$ 17,021,950.00
00006	Medical Trans Reg 2 Optional year 2	$ 17,475,308.00
00007	Medical Trans Reg 3 Years 1 through 3	$ 46,581,911.00
00008	Medical trans Reg 3 Optional Year 1	$ 17,138,917.00
00009	Medical Trans Reg 3 Optional Year 2	$ 17,595,386.00

Also on December 3, 2010, MMO posted the Intent to Award to Logisticare for region 1 (Contract Number 4400003143) with a December 14, 2010 effective date as noted below:

Total Potential Value: $ 72,607,425.00
Maximum Contract Period: December 14, 2010 through December 13, 2015

Item	Description	Unit Price
00002	Non Emergency Medical Trans, Reg 1, Years 1 through 3	$ 39,892,608.00
00003	Medical Trans Reg 1 Optional Year 1	$ 15,824,981.00
00005	Medical Trans Reg 1 Optional Year 2	$ 16,889,837.00

MTM submitted a protest on December 3, 2010, protesting the intent to award for all three (3) regions of the state: Contract Number 4400003143 to Logisticare for Region 1 and Contract Number 4400003144 to AMR for Regions 2 and 3. Logisticare then submitted a December 13, 2010 protest. The Logisticare protest only addresses the awards to Regions 2 and 3 made to AMR. In response to protests, both intents to award were suspended on December 13, 2010.

DISCUSSION

I. **Adrain Novit's and Sonny Williams' protests must be dismissed as they do not have standing to protest the award to AMR and the CPO does not have personal jurisdiction over them.**

As stated in the December 3, 2010 Intent to Award:

> Any actual bidder, offeror, contractor, or subcontractor who is aggrieved in connection with the intended award or award of a contract shall protest within ten days of the date notification of award is posted in accordance with this code. A protest shall be in writing, shall set forth the grounds of the protest and the relief requested with enough particularity to give notice of the issues to be decided, and must be received by the appropriate Chief Procurement Officer within the time provided. [Section 11-35- 4210][1]

It is undisputed that neither Novit and Williams are an offeror, contractor, or subcontractor who is aggrieved in connection with the intended award. See Evaluation Score Sheet Summary attached hereto as Exhibit 1. The South Carolina Procurement Review Panel (Panel) has repeatedly held that only an actual offeror has standing to protest an award or intended award. See, e.g., Protest of Winyah Dispensary, Inc., Case No. 1994-18; Protest of Smith & Jones Distrib. Co., Case No. 1994-5; Protest of Eastern Data, Inc., Case No. 1993-9; Protest of Laurens Co. Serv. Council for Senior Citizens, Case No. 1990-18; Protest of Quantum Res., Case No. 1990-17; see also Protest of Unknown Person (alias Jim Jones) vs. S.C. State Univ., Case No. 2007-5. Therefore, AMR respectfully requests that these protests be dismissed as a matter of law.

As a creature of statute, the CPO's authority is dependent upon statute – in this case, the Procurement Review Code. See City of Columbia v. Bd. of Health and Envtl. Control, 292 S.C. 199, 355 S.E.2d 536 (1987). Clearly, the CPO only has the statutory authority to hear a protest from an actual offeror, contractor, or subcontractor. Since Novit and Williams are not actual offerors herein, the CPO does not have personal jurisdiction over Novit and Williams and cannot hear the protest.

---

[1] Section 11-35-4210(b) provides, in pertinent part: "Any actual bidder, offeror, contractor, or subcontractor who is aggrieved in connection with the intended award or award of a contract shall protest to the appropriate chief procurement officer in the manner stated in subsection (2)(b) within ten days of the date of award or notification of intent to award, whichever is earlier, is posted in accordance with this code; ... ."

II. **Even if Novit had standing, her protest must be dismissed as it was not timely filed.**

As stated above S.C. Code Ann. § 11-35- 4210 requires that a protest (1) be received by the CPO (2) within ten (10) days of the date notification of award is posted. In this case, the award was posted on December 3, 2010. Therefore, any protest must have been received by the CPO by December 13, 2010.

Novit's email was sent to Daniel Covey on December 14, 2010, thereby missing the December 13, 2010 statutory deadline. See Exhibit 2, E-mail from Novit to Covey dated December 14, 2010. While Novit stated that she attempted to email Mr. Covey the day before, she admitted that she had not used the correct email address and the protest was not filed until December 14, 2010.

> The South Carolina Procurement Review Panel (Panel) has repeatedly held that the time for filing cannot be waived. See, In Re: Protest of Jones Engineering Sales, Inc., Case No. 2001-8 (finding that the CPO did not have jurisdiction to rule on the protest issue because the time for filing protests of the solicitation is jurisdictional and may not be waived); In Re: Protest of National Cosmetology Ass'n, Case No. 1996-17 (finding "where the appeal is not taking within the time provided, jurisdiction cannot be conferred by consent or by waiver"); In Re: Protest of Voree Corporation, Case No. 1994-9 (finding that a protest of award was untimely when it was filed one day after the deadline established by the Code prior to its amendment). The Panel has explained its rationale for why this time limit is jurisdictional and cannot be waived as follows:
>
> > [I]t is essential to the operation of government that challenges to its purchasing decision be limited. If the time for filing protests can be waived, the state will be unable to determine with certainty when it can enter into a contract with one vendor for vital foods and services without the danger of being liable to another vendor.

In Re: Protest of Oakland Janitorial Services, Inc., Case No. 1988-13. As such, the protest filed by Novit was not received in a timely manner and should be dismissed as a matter of law.

III. **Matters that could have been raised pursuant to S.C. Code Ann. § 11-35-4210(1)(a) as a protest of the solicitation may not be raised as a protest of the award or intended award of a contract and therefore must be dismissed as untimely.**

The Code provides two (2) opportunities for protest: S.C. Code Ann. § 11-35-4210(1)(a) provides rights to prospective bidders aggrieved by the Solicitation's requirements while S.C. Code Ann. § 11-35-4210(1)(b) allows actual bidders to protest when aggrieved by an intent to award. See, In Re: Protest of SuperFlow Technologies Group, Case No. 2010-107. Regarding protest of a solicitation, S.C. Code Ann. § 11-35-4210(1)(a) states that:

> A prospective bidder, offeror, contractor, or subcontractor who is aggrieved in connection with the solicitation of a contract shall protest to the appropriate chief procurement officer in the manner stated in subsection (2)(a) within fifteen days of the date of issuance of the Invitation For Bids or Requests for Proposals or other solicitation documents, whichever is applicable, or any amendment to it, if the amendment is at issue. An Invitation for Bids or Request for Proposals or other solicitation document, not including an amendment to it, is considered to have been issued on the date required notice of the issuance is given in accordance with this code. (Emphasis added).

In the recent protest In Re: Protest of SuperFlow Technologies Group, SuperFlow's protest was found to be untimely because it challenged the specifications, not the award. In dismissing the protest, the CPO stated that:

> The South Carolina Procurement Review Panel (Panel) has agreed that a prospective vendor must protest allegedly defective specifications within the time limits of Section 11-35-4110(1)(a) and must not wait until he loses the contract to complain. See Protest of the Computer Group, Case No. 1996-6. In other words, a matter that could have been raised as a protest of the solicitation may not be raised as a protest of the intended award.

In Re: Protest of SuperFlow Technologies Group, Case No. 2010-107, p. 4. Furthermore the Panel, has held, "[t]he issuance of the intent to award does not modify or extend the statutorily

established time to protest a solicitation or amendment document." Protest of First Sun EAP Alliance, Inc. Case No. 1994-11.

The following issues raised by MTM could have and should have been raised as a protest of the Solicitation or as a protest of Amendment No. 1 and are untimely:

1) Issues contained in Section 1 Pricing, subsection (a) Federal law and CMS Regulations of MTM's December 10, 2010 Protest, specifically including:

a. Medicaid population eligibility is so volatile that fixed, flat rate pricing where the broker assumes all risk of increases in the number of eligible beneficiaries is unconscionable, resulting in pure speculation by all bidders, and not consistent with commercially sound business practices, nor with federal laws and CMS regulation requiring actuarial sound pricing of federal government participation contracts. MTM protest p. 1, ¶(1)(a); Solicitation [07-7A040-1] page 103, §VII.A .

b. The failure by the State of South Carolina in not having obtained an actuarial study of the expected costs of its Medicaid NEMT program for this RFP constitutes a violation of the Deficit Reduction Act and CMS regulations. p. 2, ¶(1)(a)(ii). Amendment # 1, Vendor No. 5, question 6, p. 17, Vendor No. 6, question 11, pp. 19-20 and question 21, p. 22.

c. A risk based, fixed, flat rate 3-5 year service contract entices speculative bidding without actuarially sound pricing parameters, and constitutes a denial of due process and equal protection of the law to MTM, in violation of the 5th and 14th amendments to the U.S. Constitution. p. 2, ¶(1)(a)(iii). Amendment # 1, Vendor No. 5, question 6, p. 17 and Vendor No. 6, question 11, pp. 19-20 and question 21, p. 22.

d. [A]t 42 CFR 438.6(c)(4)... : The State must provide ... actuarial certification of the capitation rates. p. 3, ¶(1)(a)(iv). Amendment # 1, Vendor No. 5, question 6, p. 17 and Vendor No. 6, question 11, pp. 19-20 and question 21, p. 22.

e. MTM submits that the State does not have a current actuarial certification as to the costs of its Medicaid NEMT services

program. p. 3, ¶(1)(a)(v). Amendment # 1, Vendor No. 5, question 6, p. 17 and Vendor No. 6, question 11, pp. 19-20.

See Exhibit 3, Solicitation p. 103 and Exhibit 4, Amendment 1, pages 17, 19, 20, and 22. Potential offerors were on notice of each of these issues by virtue of Solicitation requirements contained at the above referenced pages and sections of the Solicitation. MTM was required to protest each of these Solicitation requirements with 15 days of the solicitation, in other words not later than September 24, 2010 or within 15 days of Amendment 1, no later than October 18, 2010.

2) Issues contained in Section 4) Accreditation of MTM's December 10, 2010 Protest stating that AMR's proposal should have been thrown out as nonresponsive because AMR is not accredited by URAC or NCQA should have been protested within fifteen (15) days of the first Amendment or October 18, 2010. The Amendment 1 clarified that the URAC and NCQA were merely examples of accrediting bodies and there was no requirement that a bidder have either of those specific accreditations. See Exhibit 5, Amendment 1, Modification 3 to RFP § 2.3.2, p. 2-3. If MTM was aggrieved by the accrediting body amendment, it had the statutory obligation to protest the change within 15 days of issuance of the October 3, 2010 Amendment 1.

As such, these issues must be dismissed pursuant to S.C. Code Ann. § 11-35-4210(1)(a). MTM's opportunity to protest these matters was within fifteen (15) days of the solicitation document at issue being posted.

IV. Allegations which fail to state a cause of action upon which relief can be granted should be dismissed as a matter of law.

To the extent that MTM's allegations related to 42 CFR 438.6(c)(4) are not dismissed for the reasons discussed above, they also fail to state a cause of action upon which relief can be granted because 42 CFR 438.6(c)(4) is not relevant to this type of contract. See a copy of 42 CFR 438.6(c)(4) attached hereto for the convenience of the CPO. 42 CFR § 438.6(c)(4) requirements relate to managed care. Specifically the scope of part 438 is as follows:

> This part sets forth requirements, prohibitions, and procedures for the provision of Medicaid services through MCOs, PIHPs, PAHPs, and PCCMs. Requirements vary depending on the type of entity and on the authority under which the State contracts with the entity. Provisions that apply only when the contract is under a mandatory managed care program authorized by section 1932(a)(1)(A) of the Act are identified as such.

42 CFR 438.1(b). This procurement does not involve the provision of Medicaid services through a Managed Care Organizations (MCO), Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP), or Primary Care Case Management (PCCM). Rather, as stated clearly in the RFP, the federal requirements related to this procurement are described in 42 CFR §440.170(a) (4). See RFP § 1.1, p. 20.

CFR §440.170(a) (4) allows the State to "provide for the establishment of a non-emergency medical transportation brokerage program in order to more cost-effectively provide non-emergency medical transportation services for individuals eligible for medical assistance under the State plan who need access to medical care or services, and have no other means of transportation." Entities providing non-emergency medical transportation under contract are required to meet the following requirements:

> (A) Is selected through a competitive bidding process that is consistent with 45 CFR 92.36(b) through (i) and is based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs.
> (B) Has oversight procedures to monitor beneficiary access and complaints and ensure that transportation is timely and that transport personnel are licensed, qualified, competent, and courteous.
> (C) Is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services.
> (D) Is subject to a written contract that imposes the requirements related to prohibitions on referrals and conflicts of interest described at § 440.170(a)(4)(ii), and provides for the broker to be liable for the full cost of services resulting from a prohibited referral or subcontract.

42 CFR §440.170(a)(4)(i). There is absolutely no reference to the requirements of § 438 in the CFR Section relevant to this procurement. In relying on a CFR Section that is not applicable to this procurement, MTM fails to state a cause of action upon which relief can be granted.

Additionally, Section 5 of MTM's 12/10/2010 Protest titled "Contract Service Implementation" fails to state a cause of action upon which relief can be granted. Additional requirements, terms, or conditions not specified in the Solicitation or otherwise required by law cannot be imposed subsequently on an offeror. See, e.g., Tall Tower, 294 S.C. at 234, 363 S.E.2d at 687-88; In re: Protest of First Sun EAP Alliance, Inc, Case No. 1994-11. Whether or not AMR is commencing business in another location the day after South Carolina services are to be commenced is irrelevant to this matter. Furthermore, MTM has pointed to no requirements in the IFB that required AMR to disclose any settlements, audits, or implementation dates in other states. See In re: Protest of CareCore National, LLC, Case No. 2010-137, p. 7, where CareCore's protest failed because CareCore could not point to any language in the IFB making the requirements CareCore sought to impose on the winning bidder. As such, these allegations should be dismissed as a matter of law.

V. Allegations that are overly broad and vague in contravention of the requirements of S.C. Code Ann. § 11-35-4210(2) (Supp. 2009) should be dismissed as a matter of law.

S.C. Code Ann. § 11-35-4210(2)(b) requires that a protest "set forth both the grounds of the protest and the relief requests with enough particularity to give notice of the issues to be decided." The following allegations contained in MTM's December 10, 2010 protest letter are overly broad and vague in contravention of the requirements of S.C. Code Ann. § 11-35-4210(2) (Supp. 2009) and should be dismissed as a matter of law:

> The Deficit Reduction Act of 2005 and Regulations promulgated by the Centers for Medicare and Medicaid Services (CMS) require that risk based contracts be actuarially sound with respect to pricing. The intent of the federal law and CMS Regulations was to promote competitive pricing for government services contracts, while avoiding the selection of a contractor's bid whose price is below an actuarial sound range of pricing, to ensure the government has no interruption in services based upon a contractor incurring significant operational losses resulting from "low ball," predatory bid pricing. In other words, the federal government wants to obtain competitively fair rates for the provision of Medicaid NEMT services, but it does not want such federally subsidized State contracts to be awarded to bidders who submit unrealistically low pricing bids that are arbitrary or otherwise consist of a bidder engaged in predatory pricing simply to "buy the contract" at any cost. (p. 2, ¶ i)
>
> The State has not provided any certification from an actuary that AMR's bid is within a price range certified as being actuarially sound for this risk based (sic)NEMT services contract. MTM submits that the State does not have a current actuarial certification as to the costs of its Medicaid NEMT services program, and therefore cannot certify that AMR's bid is actuarially sound and not arbitrarily and unrealistically low, based upon MTM"s belief that AMR is simply trying to "buy the contract." MTM contends that the CMS regulations referenced herein were enacted to prevent the exact situation that has occurred here, whereby AMR and Logisticare have submitted actuarially unsound, unrealistically low, commercially unreasonable, and predatorially priced bids in order to "buy the contract." (p. 3, ¶ v)
>
> Because the State did not commission a new actuarial study for this solicitation as it should have, a review of the State's prior actuarial study, with trending forward to the present, is necessary to determine the actuarial soundness, and commercial reasonableness, of the rates submitted by AMR and Logisticare. The

State had previously commissioned Milliman to determine the range of actuarially sound rates for the period March 2009-February 2010. A copy of the Milliman study is attached hereto as Exhibit A. The Milliman study primarily used 2008 data, which is now two (2) years outdated and doesn't capture the devastating downturn in the economy that occurred between 2008-2010 that left many people out of work, adding them to the Medicaid eligibility rolls at a rate faster than normal. MTM has taken the Milliman study, assuming the trending rates identified in the study and used by Milliman, and trended and extrapolated these Milliman actuarially sound rates forward for the initial 3 year contract period, and for the 2 option years. The results of this analysis are found in the attached Exhibit B. (p. 3, ¶ vi)

For the initial 3 year contract period, AMR bid $46,264,005 for Region 2 and $46,581,911 for Region 3. **The Milliman study, applying the same assumptions and trending percentages, would suggest that actuarially sound bids for Region 2 would have a range between a low of $65,813,836 and a high of $87,288,278. AMR bid $46,264,005, more than $19.5 million less (and 29.7% lower than) the lowest actuarially sound rate! For Region 3 the Milliman study would suggest that actuarially sound rates would have a range of a low of $70,121,790 and a high of $93,695,874. AMR bid $46,581,911, which is $23.5 million less (and 33.5% less than) the lowest actuarially sound rate!**

Similarly, in the option years of the solicitation (Years 4 and 5), the Milliman study trended forward would suggest for Region 2 a range of a low of $27,314,976 and a high of $39,714,187 for Option Year 1, and a range of a low of $29,235,805 and a high of $44,671,379 for Option Year 2. AMR bid $17,021,950 for Option Year 1 and $17,475,308 for Option Year 2 in Region 2, over $22 million less (and 39% lower than) the lowest actuarially sound rate! For the option years in Region 3, the Milliman study would trend and project a range of a low of $28,974,201 and a high of $42,446,255 for Option Year 1, and a range of a low of $30,945,153 and a high of $47,643,149 for Option Year 2. AMR bid $17,138,917 in Option Year 1 and $17,595,386 in Option Year 2 in Region 3, more than $25 million less (and 42% lower than) the lowest actuarially sound rate! (p. 4, ¶ b.i) [emphasis added or in original]

The unrealistically low, actuarially unsound pricing also results from AMR's minimal experience managing a State-wide Medicaid NEMT program. Such commercially unreasonable, predatory pricing from inexperienced companies such as AMR is exactly what the federal government and CMS were intending to prohibit in the enactment of the Deficit Reduction Act and promulgation of the above CMS Regulations. (p. 4, ¶ b.ii)

AMR doesn't even have a single year of State-wide NEMT experience, but yet technically they were scored higher than MTM which has over 15 years of NEMT

> experience, including 12 years of State-wide NEMT contract experience, and the successful operation of South Carolina's program in the former Regions 1 and 2. This is another example of the arbitrariness and capriciousness of the evaluators against MTM. The evaluation and scoring has denied MTM due process and equal protection of the law, in violation of the 5th and 14th amendments to the U.S. Constitution, and applicable South Carolina law. (p. 9, ¶ 4)
>
> Commencement of service in South Carolina is March 1, 2011. The State has selected AMR to provide NEMT services in Regions 2 and 3, the greater portion of the State. Possibly unknown to South Carolina, which desires and expects smooth implementation of contract services, is that AMR is already committed to commence NEMT services implementation in Nebraska on the same day, March 1, 2011. MTM suggests that the State did not appropriately consider the high likelihood of significant and material service failures, breakdowns and interruptions when it chose AMR. (p. 9, ¶ 5)

These statements do not contain allegations that AMR has violated any specific or particular requirement of the RFP. Therefore, AMR is not on notice of what issues MTM seeks to have decided.

The Panel has addressed the issue of vagueness on numerous occasions. In In re: Protest By J&T Technology, Inc., Case No. 1987-3, 1987 WL 863241, the CPO found that, "Implicit under § 11-35-4210 is the requirement that protestants state their grievance with enough specificity to put all parties on notice of the issues to be decided by the CPO and the CPO. The state is under no obligation to reformulate or perfect a protestant's grievance." (Emphasis added.)

Further, in In re: Protest of NBS Imaging Systems, Inc.; Appeal by NBS Imaging Systems, Inc., Case No. 1993-16, 1993 WL 13005237, the Panel was faced with a protest ground which read: "Unisys did not meet the RFP requirements for system design, technical specifications, technical support, and maintenance support." (NBS, p. 3.) Unisys moved, prior to the hearing, to dismiss this protest ground as being overly vague to the point that it violated Section 11-35-

4210 and due process. In determining that the above protest ground was vague, the Panel held:

> The Panel finds that the statement of NBS' issue on the specifications of the RFP is too vague to meet the requirements of SC Code Section 11-35-4210. ... The larger the RFP and its requirements, the more specific a protestant will need to be to state its grievance and give notice of the issues of protest. The Panel held in In re: Protest by J&T Technology, Case No. 1987-3, 'implicit under Section 11-35-4210 is the requirement that protestants state their grievance with enough specificity to put all parties on notice of the issues to be decided.' NBS' protest concerning the RFP specifications states only broad areas of RFP requirements. In a procurement of this size, more specificity is required to indicate the protestants grievance and to give notice of the issues raised.

In re: Protest of NBS Imaging Systems, Inc.; Appeal by NBS Imaging Systems, Inc.

Just as in the NBS case, MTM has made general, vague unsubstantiated allegations against AMR and has not stated its grievances with enough specificity to put all parties on notice of the issues to be decided. Furthermore, MTM has not cited any specific section of the Deficit Reduction Act in its allegations. As such, the allegations listed above should be dismissed as a matter of law.

CONCLUSION

Based upon the foregoing reasons, AMR respectfully requests that the Novit protest, the Williams protest, and the above-cited grounds of MTM's protest be dismissed as a matter of law.

[signature on following page]

M. Elizabeth Crum
Ariail Burnside Kirk
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By: Ariail C Burnside Kirk

Attorneys for American Medical Response, Inc.

January 18, 2011

Columbia, South Carolina.

REGION 1

Offeror		Eval. 1	Eval. 2	Eval. 3	Eval. 4	Eval. 5	Total
AMR							
1 Technical Approach (0-45)		36	42	37	30	36	181
2 Price (0-30)		30	30	30	30	30	150
3 Corporate Background, Experience and Approach to Staffing (0-25)		20	23	21	20	22	106
	Totals	86	95	88	80	88	437
							437

Offeror		Eval. 1	Eval. 2	Eval. 3	Eval. 4	Eval. 5	Total
Logisticare							
1 Technical Approach (0-45)		38	44	36	39	37	194
2 Price (0-30)		28.92	28.92	28.92	28.92	28.92	144.6
3 Corporate Background, Experience and Approach to Staffing (0-25)		22	24	22	22	23	113
	Totals	88.92	96.92	86.92	89.92	88.92	451.6
							451.6

Offeror		Eval. 1	Eval. 2	Eval. 3	Eval. 4	Eval. 5	Total
MTM							
1 Technical Approach (0-45)		29	43	20	35	29	156
2 Price (0-30)		26.49	26.49	26.49	26.49	26.49	132.45
3 Corporate Background, Experience and Approach to Staffing (0-25)		20	23	20	23	20	106
	Totals	75.49	92.49	66.49	84.49	75.49	394.45
							394.45

		Eval. 1	Eval. 2	Eval. 3	Eval. 4	Eval. 5	Total
Southeastrans							
1 Technical Approach (0-45)		35	41	28	28	27	159
2 Price (0-30)		20.53	20.53	20.53	20.53	20.53	102.65
3 Corporate Background, Experience and Approach to Staffing (0-25)		21	21	18	18	19	97
	Totals	76.53	82.53	66.53	66.53	66.53	358.65
							358.65

-----Original Message-----
From: Novit, Adrian [mailto:novit@musc.edu]
Sent: Tuesday, December 14, 2010 10:18 AM
To: Covey, Daniel
Subject: Urgent- FW: Protest- solicitation#5400002201

Dear Mr. Covey,
Please see the attached email below. Unfortunately I sent this email to the wrong email address last night (I misspelled your name). I hope this letter isn't too late for the protest deadline.
Thank you for your time in this matter.

Adrian Novit, PhD
Program Coordinator/Clinical Psychologist MUSC STAR Children's Day Treatment Program
3495 Iron Horse Dr
Ladson, SC 29456
Phone: 843-875-8510
Fax: 843-875-8523

-----Original Message-----
From: Novit, Adrian [mailto:novit@musc.edu]
Sent: Monday, December 13, 2010 4:29 PM
To: 'dkovey@mmo.sc.gov'
Subject: Protest- solicitation#5400002201

Dear Mr. Kovey,
I just received word that our current nonemergency medical transportation broker (Logisticare-solicitation #5400002201) will no longer be our broker as of Feb, 2011. I am writing this protest in an email because I understand the cut-off date for a protest is 12/14/10 and I just found out about this today so there won't be enough time to mail a protest to your office.
It is very distressing to our agency to learn about this because a disruption in brokers will interfere with our continuity of care and we will likely not be able to receive the special services/program that we have been receiving from Logisitcare. Our agency is a Children's Day Treatment Program where clients (ages 4-13yrs) attend our program every day M-F (8:15-3:15) instead of attending regular school because their severe psychiatric issues impede their ability to successfully function in regular school. I worry that if we

EXHIBIT
tabbies
2

lose Logisticare, our program will not succeed because we will no longer have transportation for our clients. Logisticare has worked very closely with our program to provide us with a specially-tailored transportation program where one contractor (DJ's transportation) exclusively provides transportation for our clients (and provides an escort). This particular company was hand-picked by Logisticare because the owner is sensitive to and understands the special needs of our clients. Also, Logisticare has set up a special program for our agency to submit standing orders directly to the Region 6 Manager (Krista Martin) which gets transportation arranged much quicker and smoother than going through facilities assistance and getting a different person every time (and having to explain our program and clients to a different person every time). Without the efforts and assistance of Krista Martin and Logisticare, our agency would have likely shut down last year because we would not have had transportation for our clients to attend our program every day.

I urge you to please reconsider your decision and give the contract back to Logisticare. Our agency and the clients we serve in 4 counties (Charleston, Berkeley, Dorchester, Colleton) will likely have to shut down if we don't have Logisticare helping us with transportation. We provide a vital service to the communities but we need Logisticare to survive and continue providing quality programs.

Thank you for your time. If you have any further questions or comments, I can be reached at this email or you can call me at 843-875-8510.

Sincerely,

Adrian Novit, PhD
Program Coordinator/Clinical Psychologist MUSC STAR Children's Day Treatment Program
3495 Iron Horse Dr
Ladson, SC 29456
Phone: 843-875-8510
Fax: 843-875-8523

	State of South Carolina **Request for Proposal**	Solicitation Number: Date Issued: Procurement Officer: Phone: E-Mail Address:	5400002201 September 9, 2010 Daniel W. Covey, CPPB 803-737-0674 dcovey@mmo.sc.gov

DESCRIPTION: **Provide Non-Emergency Transportation Services**

USING GOVERNMENTAL UNIT: **SC Department of Health & Human Services**

The Term "Offer" Means Your "Bid" or "Proposal". Unless submitted on-line, your offer must be submitted in a sealed package. Solicitation Number & Opening Date must appear on package exterior. See "Submitting Your Offer" provision.

SUBMIT YOUR SEALED OFFER TO EITHER OF THE FOLLOWING ADDRESSES:

MAILING ADDRESS:	PHYSICAL ADDRESS:
Materials Management Office PO Box 101103 Columbia SC 29211	Materials Management Office Capital Center 1201 Main Street, Suite 600 Columbia SC 29201

SUBMIT OFFER BY (Opening Date/Time): **10/25/2010 2:30 PM** (See "Deadline For Submission Of Offer" provision)

QUESTIONS MUST BE RECEIVED BY: **09/21/2010 5:00 PM** (See "Questions From Offerors" provision)

NUMBER OF COPIES TO BE SUBMITTED: **One (1) original in hard copy, one (1) electronic copy (See MAGNETIC MEDIA -- REQUIRED FORMAT – Section II B), five (5) copies in hard copy clearly marked "COPY", one (1) redacted copy in hard copy and one (1) redacted electronic copy (see SUBMITTING CONFIDENTIAL INFORMATION – Sec. II A and SUBMITTING REDACTED OFFERS – Sect. 4.)**

CONFERENCE TYPE: **Pre-Proposal** DATE & TIME: **09/20/2010 11:30 AM** (As appropriate, see "Conferences - Pre-Bid/Proposal" & "Site Visit" provisions)	LOCATION: Materials Management Office Conference Room 1201 Main Street – Suite 600 Columbia, SC 29201

AWARD & AMENDMENTS	Award will be posted on 11/22/2010. The award, this solicitation, any amendments, and any related notices will be posted at the following web address: http://www.procurement.sc.gov

Unless submitted on-line, you must submit a signed copy of this form with Your Offer. By submitting a bid or proposal, You agree to be bound by the terms of the Solicitation. You agree to hold Your Offer open for a minimum of thirty (30) calendar days after the Opening Date. (See "Signing Your Offer" and "Electronic Signature" provisions.)

NAME OF OFFEROR (full legal name of business submitting the offer)		Any award issued will be issued to, and the contract will be formed with, the entity identified as the Offeror. The entity named as the offeror must be a single and distinct legal entity. Do not use the name of a branch office or a division of a larger entity if the branch or division is not a separate legal entity, i.e., a separate corporation, partnership, sole proprietorship, etc.
AUTHORIZED SIGNATURE (Person must be authorized to submit binding offer to contract on behalf of Offeror.)		TAXPAYER IDENTIFICATION NO. (See "Taxpayer Identification Number" provision)
TITLE (business title of person signing above)		STATE VENDOR NO. (Register to Obtain S.C. Vendor No. at www.procurement.sc.gov)
PRINTED NAME (printed name of person signing above)	DATE SIGNED	STATE OF INCORPORATION (If you are a corporation, identify the state of incorporation.)

OFFEROR'S TYPE OF ENTITY: (Check one) (See "Signing Your Offer" provision.)

___ Sole Proprietorship ___ Partnership ___ Other_____

___ Corporate entity (not tax-exempt) ___ Corporation (tax-exempt) ___ Government entity (federal, state, or local)

EXHIBIT 3

individual invoices.

(b) In connection with any discount offered for prompt payment, time shall be computed from the date of the invoice. If the Contractor has not placed a date on the invoice, the due date shall be calculated from the date the designated billing office receives a proper invoice, provided the state annotates such invoice with the date of receipt at the time of receipt. For the purpose of computing the discount earned, payment shall be considered to have been made on the date that appears on the payment check or, for an electronic funds transfer, the specified payment date. When the discount date falls on a Saturday, Sunday, or legal holiday when Federal Government offices are closed and Government business is not expected to be conducted, payment may be made on the following business day
[07-7A020-1]

DISPUTES (JAN 2006)

(1) Choice-of-Forum. All disputes, claims, or controversies relating to the Agreement shall be resolved exclusively by the appropriate Chief Procurement Officer in accordance with Title 11, Chapter 35, Article 17 of the South Carolina Code of Laws, or in the absence of jurisdiction, only in the Court of Common Pleas for, or a federal court located in, Richland County, State of South Carolina. Contractor agrees that any act by the Government regarding the Agreement is not a waiver of either the Government's sovereign immunity or the Government's immunity under the Eleventh Amendment of the United State's Constitution. As used in this paragraph, the term "Agreement" means any transaction or agreement arising out of, relating to, or contemplated by the solicitation. (2) Service of Process. Contractor consents that any papers, notices, or process necessary or proper for the initiation or continuation of any disputes, claims, or controversies relating to the Agreement; for any court action in connection therewith; or for the entry of judgment on any award made, may be served on Contractor by certified mail (return receipt requested) addressed to Contractor at the address provided as the Notice Address on Page Two or by personal service or by any other manner that is permitted by law, in or outside South Carolina. Notice by certified mail is deemed duly given upon deposit in the United States mail. [07-7A025-1]

EQUAL OPPORTUNITY (JAN 2006)

Contractor is referred to and shall comply with all applicable provisions, if any, of Title 41, Part 60 of the Code of Federal Regulations, including but not limited to Sections 60-1.4, 60-4.2, 60-4.3, 60-250.5(a), and 60-741.5(a), which are hereby incorporated by reference. [07-7A030-1]

FALSE CLAIMS (JAN 2006)

According to the S.C. Code of Laws Section 16-13-240, "a person who by false pretense or representation obtains the signature of a person to a written instrument or obtains from another person any chattel, money, valuable security, or other property, real or personal, with intent to cheat and defraud a person of that property is guilty" of a crime. [07-7A035-1]

FIXED PRICING REQUIRED (JAN 2006)

Any pricing provided by contractor shall include all costs for performing the work associated with that price. Except as otherwise provided in this solicitation, contractor's price shall be fixed for the duration of this contract, including option terms. This clause does not prohibit contractor from offering lower pricing after award. [07-7A040-1]

NON-INDEMNIFICATION (JAN 2006)

	State of South Carolina **AMENDMENT 1**	Solicitation Number: Date Issued: Procurement Officer: Phone: E-Mail Address:	5400002201 October 3, 2010 Daniel W. Covey, CPPB 803-737-0674 dcovey@mmo.sc.gov

DESCRIPTION: **Provide Non-Emergency Transportation Services**

USING GOVERNMENTAL UNIT: **SC Department of Health & Human Services**

The Term "Offer" Means Your "Bid" or "Proposal". Unless submitted on-line, your offer must be submitted in a sealed package. Solicitation Number & Opening Date must appear on package exterior. See "Submitting Your Offer" provision.

SUBMIT YOUR SEALED OFFER TO EITHER OF THE FOLLOWING ADDRESSES:

MAILING ADDRESS:	PHYSICAL ADDRESS:
Materials Management Office PO Box 101103 Columbia SC 29211	Materials Management Office Capital Center 1201 Main Street, Suite 600 Columbia SC 29201

SUBMIT OFFER BY (Opening Date/Time): **10/25/2010 2:30 PM** (See "Deadline For Submission Of Offer" provision)

QUESTIONS MUST BE RECEIVED BY: **09/21/2010 5:00 PM** (See "Questions From Offerors" provision)

NUMBER OF COPIES TO BE SUBMITTED: **One (1) original in hard copy, one (1) electronic copy (See MAGNETIC MEDIA -- REQUIRED FORMAT – Section II B), five (5) copies in hard copy clearly marked "COPY", one (1) redacted copy in hard copy and one (1) redacted electronic copy (see SUBMITTING CONFIDENTIAL INFORMATION – Sec. II A and SUBMITTING REDACTED OFFERS – Sect. 4.)**

CONFERENCE TYPE: **Pre-Proposal** DATE & TIME: **09/20/2010 11:30 AM** (As appropriate, see "Conferences - Pre-Bid/Proposal" & "Site Visit" provisions)	LOCATION: Materials Management Office Conference Room 1201 Main Street – Suite 600 Columbia, SC 29201
AWARD & AMENDMENTS	Award will be posted on 11/22/2010. The award, this solicitation, any amendments, and any related notices will be posted at the following web address: http://www.procurement.sc.gov

Unless submitted on-line, you must submit a signed copy of this form with Your Offer. By submitting a bid or proposal, You agree to be bound by the terms of the Solicitation. You agree to hold Your Offer open for a minimum of ninety (90) calendar days after the Opening Date. (See "Signing Your Offer" and "Electronic Signature" provisions.)

NAME OF OFFEROR (full legal name of business submitting the offer)		Any award issued will be issued to, and the contract will be formed with, the entity identified as the Offeror. The entity named as the offeror must be a single and distinct legal entity. Do not use the name of a branch office or a division of a larger entity if the branch or division is not a separate legal entity, i.e., a separate corporation, partnership, sole proprietorship, etc.
AUTHORIZED SIGNATURE (Person must be authorized to submit binding offer to contract on behalf of Offeror.)		TAXPAYER IDENTIFICATION NO. (See "Taxpayer Identification Number" provision)
TITLE (business title of person signing above)		STATE VENDOR NO. (Register to Obtain S.C. Vendor No. at www.procurement.sc.gov)
PRINTED NAME (printed name of person signing above)	DATE SIGNED	STATE OF INCORPORATION (If you are a corporation, identify the state of incorporation.)

OFFEROR'S TYPE OF ENTITY: (Check one) (See "Signing Your Offer" provision.)

___ Sole Proprietorship ___ Partnership ___ Other_____

___ Corporate entity (not tax-exempt) ___ Corporation (tax-exempt) ___ Government entity (federal, state, or local)

EXHIBIT 4

3. References: Can the RFP ask offerors if they have ever had an NEMT contracted terminated or if they have ever terminated an NEMT contract?

Answer: See Article V. Section 3(a).

4. Subcontractors: do the requirements of the state and federal clauses, certifications and assurances included in the RFP pass through to subcontractors? Examples: must the broker insure that subcontractors and/or providers have never been debarred, suspended, etc. as defined in 45CFR Part 76? Must a subcontractor comply with the Drug Free Workplace requirements?

Answer: Yes.

5. VI Award Criteria – Evaluation Factors: Please explain how the numerical assignments were determined.

Answer: SCDHHS determined the numerical assignments for each evaluation factor.

6. Section 3.16.3: Fuel Cost Adjustment During Emergency Situations: Absent any requirement that increases in broker payments for fuel cost adjustments be passed along to providers, why is this section included? Why is SCDHHS using the quarterly average price index for the east coast region (PADD1) as a calculation factor when the South Carolina quarterly average price index would be far more accurate in determining fuel price volatility for South Carolina NEMT eligibles? Further, is there any consideration for the cumulative (semi-annual or annual, for example) effects of fuel cost increases of less than 20% per quarter but which have a semi-annual or annual effect of increases greater than 20%? If gas is $2.50 per gallon and increases 19% to $2.975 during quarter one, then increases 18% to $3.51 per gallon during quarter 2, the effect is well above the 20% mark for the 6 month period yet would not qualify for an adjustment.

Answer: The Broker will be responsible for determining the extent to which transportation providers are compensated for fuel price fluctuations. SCDHHS selected the PADD1 index because it is a nationally recognized index managed by the US Energy Information Administration that does include fuel prices for South Carolina and has also been referenced in the determination of the actuarially soundness of the NEMT program in South Carolina. Section 3.16.3 addresses fuel cost adjustments for emergency situations. See section IV (b) and Appendix P-2 for fuel adjustment considerations during non emergency conditions.

7. Cost Details for Fixed Price Proposals, Appendices P-1 and P-2: Under Section B, Transportation Costs, can SCDHHS provide a definition of "transportation costs"?

Answer: Offerors must determine the cost they expect to pay for transportation.

the call center will have to staff to peak volume at all times to meet the daily requirements.

Answer: See Section 3.5.2 and Modification 10.

8. Page 19, 1.1: If a bidder is submitting a bid per region as well as a Statewide bid, we assume that we would have to submit four responses, one per region and one for the statewide business and each would contain a P-1 and P-2 (with the statewide offering discounts based on scalability), is this assumption correct?

Answer: No. A bid must be submitted for each region the Offeror is interested in bidding on. SCDHHS is not accepting statewide bids.

9. If the state only negotiates discounts based on economies of scale with a bidder that might be awarded more than one region, how does the state know that another bidder that might not have been awarded the region could not have provided a greater savings through a consolidated bid?

Answer: Regions will be evaluated and awarded individually.

10. Page 20, 1.4: Section 1.4, Past Service Volume, references the number of Medicaid eligibles in Appendix I and states that those eligible for NET services are approximately 710,000. In the last three contract periods, we have seen our monthly Medicaid membership increase by approximately 80,000 members in our regions alone (roughly 20%) and according to an August 30th, Deloitte Center for Health Solutions Bulletin, it is estimated that within the next three years the Medicaid enrollment will increase from 58.8 million to 76 Million due to HealthCare reform, approximately 31%. Has the Agency developed any forward-looking projections on the potential growth of South Carolina Medicaid enrollment that may assist all bidders and can you share with us what those growth assumptions are?

Answer: The agency has developed some forward looking projections but not specifically for the purpose of non-emergency transportation. These projections may be found on the agency's website at www.scdhhs.gov. Discovery of any inaccuracy in this data will not constitute a basis for contract rejection by any Offeror. Further discovery of any inaccuracy in this data will not constitute a basis for renegotiation of any payment rate after contract award. It remains the Offeror's responsibility to take into consideration normal volume increases over the contract period.

11. Does the agency plan on handling the effects of HealthCare reform and its effect on Medicaid membership on this fixed budget contract through annual reviews with

Milliman or is a bidder to incorporate a similar 20 to 30% increase to members, unduplicated and trip volume over the next five years in pricing this contract?

Answer: SCDHHS does not anticipate an annual outside actuarial review. The Broker should provide its best price for transportation services.

12. Page 20, 1.4: Section 1.4 Past Service Volume - we have experienced a 26% growth in unduplicated riders, which trends along with the increase in members stated above, as well as the trip volume. In addition, part of this unduplicated increase was also due to the inclusion of certain transportation programs previously managed and paid directly to certain medical facilities. Does the Agency foresee any additional programs or volume currently paid outside the NET program that it may want to include in the NET program over the next three years?

Unduplicated	
May-07	10,923
Jun-10	13,788
Variance	2,865
Growth	26.2%

Answer: SCDHHS is expecting to add the Healthy Connections Kids (HCK) population of approximately 16,000 children in the fourth quarter of calendar year 2010. However, this population currently provides its own transportation and the agency does not anticipate significant utilization of the transportation program. At this point, no additional programs are anticipated.

13. Page 25, 2.3.4: Section 2.3.4 requests financial resources to sustain services for a minimum of ninety days prior to payment. Is the purpose of this requirement to establish the financial strength of the company that is being awarded the contract? If not, what is the purpose of the requirement?

Answer: Yes, the purpose is to establish that the organization is financially viable.

14. Page 54, 3.7.11: Would the agency consider adopting the industry monthly performance standard of 98% for no-shows and 90% for on-time drop off?

Answer: No.

15. Page 33, 3.3.4: Section 3.3.4 Retroactive Eligibility states, "SCDHHS will approve the process and the rate structure based on the level of service and the region the transportation originates from." Does this provision mean that trips provided to pending members will be reimbursed on some fee per trip basis-cost pass through? If not, what

tracking, the agency is converting this program into a "closed/exclusive Medicaid only network" program, meaning that providers that support different sources of income (assisted living, nursing home private pay, Medicare, etc.) will not invest in the additional required technology just for the sake of Medicaid and will likely drop out of the program. In addition, providers may not want to share their other member's information or volume that would all be tracked by this same GPS system and downloaded. We believe that there are two negative cost impacts from this requirement. One is the actual cost of the GPS for over 1400 vehicles (which may amount to over $3.5 Million initial investment with about $500 to $700 thousand a year for turnover, replacements, etc.) that providers would have to incur and the second is a deterioration of the network for those providers that choose not to service Medicaid (which would lead to smaller network, coverage issues, higher deadhead, lower multi-load capacity, etc), thereby costing the program more dollars. Is the agency willing to accept the increased cost to the program to meet this requirement?

Answer: SCDHHS conducted research into the cost of devices capable of fulfilling the requirement. Several low cost options were identified during our research (some options for as little as $20 per month with a nominal start up fee).

21. Page 205 and 206, Appendix P-1 and P-2: Under the Yearly Fixed Cost Proposal, will the brokers have to undergo an annual financial/ encounter data review with an outside actuary or is this exercise no longer needed under this contract scenario?

Answer: SCDHHS does not anticipate an annual outside actuarial review.

22. Page 68, 3.10.4.2: Section 3.10.4.2 states that the broker must mail material to eligible Medicaid population. During the initial implementation the agency allowed the broker to mail to each household (instead of to each member) as there might be multiple members in a household. Is this still a viable option? The cost of the initial mailing to households was approximately $130,000, and household mailings, rather than individual mailings, reduced the original cost estimates significantly.

Answer: Yes, the Broker may meet the requirement of Section 3.10.4.2 by mailing to each household rather than each member.

23. Page 68, 3.10.4.2: Section 3.17 Performance Guarantee. Based on how general and all encompassing the liquidated damages are (reference by entire sections), and based on our projections, the monthly amount of liquidated damages can exceed $356,000 or roughly over $4 Million dollars a year with about an additional $200,000 in potential damages for implementation and turnover responsibilities. These LD appear very extreme in particular on a current program, which experiences a fairly high satisfaction level by the members. Would the Agency consider more specific and less punitive LD (for example $250 for every trip that is late over 30 minutes, etc) that can be

	State of South Carolina **AMENDMENT 1**	Solicitation Number: Date Issued: Procurement Officer: Phone: E-Mail Address:	5400002201 October 3, 2010 Daniel W. Covey, CPPB 803-737-0674 dcovey@mmo.sc.gov

DESCRIPTION: **Provide Non-Emergency Transportation Services**

USING GOVERNMENTAL UNIT: **SC Department of Health & Human Services**

The Term "Offer" Means Your "Bid" or "Proposal". Unless submitted on-line, your offer must be submitted in a sealed package. Solicitation Number & Opening Date must appear on package exterior. See "Submitting Your Offer" provision.

SUBMIT YOUR SEALED OFFER TO EITHER OF THE FOLLOWING ADDRESSES:

MAILING ADDRESS:	PHYSICAL ADDRESS:
Materials Management Office PO Box 101103 Columbia SC 29211	Materials Management Office Capital Center 1201 Main Street, Suite 600 Columbia SC 29201

SUBMIT OFFER BY (Opening Date/Time): **10/25/2010 2:30 PM** (See "Deadline For Submission Of Offer" provision)

QUESTIONS MUST BE RECEIVED BY: **09/21/2010 5:00 PM** (See "Questions From Offerors" provision)

NUMBER OF COPIES TO BE SUBMITTED: **One (1) original in hard copy, one (1) electronic copy (See MAGNETIC MEDIA -- REQUIRED FORMAT – Section II B), five (5) copies in hard copy clearly marked "COPY", one (1) redacted copy in hard copy and one (1) redacted electronic copy (see SUBMITTING CONFIDENTIAL INFORMATION – Sec. II A and SUBMITTING REDACTED OFFERS – Sect. 4.)**

CONFERENCE TYPE: **Pre-Proposal** DATE & TIME: **09/20/2010 11:30 AM** (As appropriate, see "Conferences - Pre-Bid/Proposal" & "Site Visit" provisions)	LOCATION: Materials Management Office Conference Room 1201 Main Street – Suite 600 Columbia, SC 29201

AWARD & AMENDMENTS	Award will be posted on 11/22/2010. The award, this solicitation, any amendments, and any related notices will be posted at the following web address: http://www.procurement.sc.gov

Unless submitted on-line, you must submit a signed copy of this form with Your Offer. By submitting a bid or proposal, You agree to be bound by the terms of the Solicitation. You agree to hold Your Offer open for a minimum of ninety (90) calendar days after the Opening Date. (See "Signing Your Offer" and "Electronic Signature" provisions.)

NAME OF OFFEROR (full legal name of business submitting the offer)		Any award issued will be issued to, and the contract will be formed with, the entity identified as the Offeror. The entity named as the offeror must be a single and distinct legal entity. Do not use the name of a branch office or a division of a larger entity if the branch or division is not a separate legal entity, i.e., a separate corporation, partnership, sole proprietorship, etc.
AUTHORIZED SIGNATURE (Person must be authorized to submit binding offer to contract on behalf of Offeror.)		TAXPAYER IDENTIFICATION NO. (See "Taxpayer Identification Number" provision)
TITLE (business title of person signing above)		STATE VENDOR NO. (Register to Obtain S.C. Vendor No. at www.procurement.sc.gov)
PRINTED NAME (printed name of person signing above)	DATE SIGNED	STATE OF INCORPORATION (If you are a corporation, identify the state of incorporation.)

OFFEROR'S TYPE OF ENTITY: (Check one) (See "Signing Your Offer" provision.)

___ Sole Proprietorship ___ Partnership ___ Other_____

___ Corporate entity (not tax-exempt) ___ Corporation (tax-exempt) ___ Government entity (federal, state, or local)

EXHIBIT 5

AMENDMENT 1

South Carolina Request for Proposal (RFP)
Solicitation Number: 5400002201
Non-Emergency Transportation Services
The Department of Health and Human Service

(a) The Solicitation may be amended at any time prior to opening. All actual and prospective Offerors should monitor the following web site for the issuance of Amendments: www.procurement.sc.gov (b) Offerors shall acknowledge receipt of any amendment to this solicitation (1) by signing and returning the amendment, (2) by identifying the amendment number and date in the space provided for this purpose on Page Two, (3) by letter, or (4) by submitting a bid that indicates in some way that the bidder received the amendment. (c) If this solicitation is amended, then all terms and conditions which are not modified remain unchanged. [02-2A005-1]

MODIFICATIONS:

1. **The State hereby amends Cover Page (Nov. 2007) as follows:**

Unless submitted on-line, you must submit a signed copy of this form with Your Offer. By submitting a bid or proposal, You agree to be bound by the terms of the Solicitation. You agree to hold Your Offer open for a minimum of **ninety (90)** calendar days after the Opening Date.

2. **The State hereby amends EVALUATION FACTORS -- PROPOSALS (JAN 2006)**

Price
30 points
The price proposal will be evaluated based on the total of all costs plus profit to the State for the **initial three (3) year** contract period.

3. **The State hereby amends Section 2.3.2 to now read as follows:**

2.3.2 The Broker must have accreditation from a nationally recognized quality improvement organization that ensures the company is conducting business in a way that conforms to national standards for quality assurance in the health care industry. Examples of such organizations include, but are not limited to, the Utilization Review Accreditation Commission (URAC) and the National Committee for Quality Assurance (NCQA). If

the Broker does not have the required accreditation, the Broker must show proof it has applied for accreditation and must be accredited no later than the third year of the contract. Failure of the Broker to attain the required accreditation and maintain the accreditation thereafter shall be considered a breach of the contract, which will result in contract termination.

4. The State hereby amends Section 3.3.18 to now read as follows:

3.3.18 Hardware/Software

The Broker's computer system must be capable of performing the following functions for daily operations and for SCDHHS audit and billing purposes:

- Recording of member's trip information
- Recording of transportation request denials
- Recording of all trip cancelations
- Recording of all trip re-route request
- Daily back-up of database
- Generation of hard copies of data for each authorized trip
- Electronic transmission of authorization data to SCDHHS
- Electronic transmission of authorizations to selected providers
- Extraction of data by member ID number for creation of history file of approvals
- Ability to generate monthly encounter data using the 837P transaction set according to the implementation guide described on the SCDHHS website
- Record all telephone calls at all locations that can be accessed to review conversations about transportation services when required

5. The State hereby amends Section 3.6.1 to now read as follows:

3.6.1 Determine Purpose of NEMT Request

The Broker must determine if the purpose of the request is to transport a member to a medical service that is covered by Medicaid (Fee for Service or Managed Care). For a transportation request not covered by Medicaid Fee for Service and the member is enrolled in a Managed Care Organization (MCO), the Broker must deny the request and refer the member to the MCO for transportation services. If the transportation request is for a non-covered service, the Broker must deny the request. A list of covered Medicaid services will be provided to the Broker. The Broker must contact a statistically significant percentage of the healthcare provider(s) to whom the Member(s) requests NEMT to verify that an appointment exists. The Broker should propose such percentage to ensure a cost-effective method that minimizes fraud and abuse. The Broker must comply with the member's freedom of choice of medical provider requirement. For transportation requests outside the SCMSA, the Broker must obtain prior approval by SCDHHS Division of Physicians Services or the member's MCO if enrolled in an MCO.

PART 438—MANAGED CARE

Subpart A—General Provisions

Sec.

Subpart B—State Responsibilities

Subpart C—Enrollee Rights and Protections

Subpart D—Quality Assessment and Performance Improvement

ACCESS STANDARDS

STRUCTURE AND OPERATION STANDARDS

MEASUREMENT AND IMPROVEMENT STANDARDS

Subpart E—External Quality Review

Subpart F—Grievance System

Subpart G [Reserved]

Subpart H—Certifications and Program Integrity

Subpart I—Sanctions

Subpart J—Conditions for Federal Financial Participation

AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

SOURCE: 67 FR 41095, June 14, 2002, unless otherwise noted.

Subpart A—General Provisions

§438.1 Basis and scope.

(a) *Statutory basis.* This part is based on sections 1902(a)(4), 1903(m), 1905(t), and 1932 of the Act.

(1) Section 1902(a)(4) requires that States provide for methods of administration that the Secretary finds necessary for proper and efficient operation of the State plan. The application of the requirements of this part to PIHPs and PAHPs that do not meet the statutory definition of an MCO or a PCCM is under the authority in section 1902(a)(4).

(2) Section 1903(m) contains requirements that apply to comprehensive risk contracts.

(3) Section 1903(m)(2)(H) provides that an enrollee who loses Medicaid eligibility for not more than 2 months may be enrolled in the succeeding month in the same MCO or PCCM if that MCO or PCCM still has a contract with the State.

(4) Section 1905(t) contains requirements that apply to PCCMs.

(5) Section 1932—

(i) Provides that, with specified exceptions, a State may require Medicaid recipients to enroll in MCOs or PCCMs;

(ii) Establishes the rules that MCOs, PCCMs, the State, and the contracts between the State and those entities must meet, including compliance with requirements in sections 1903(m) and 1905(t) of the Act that are implemented in this part;

(iii) Establishes protections for enrollees of MCOs and PCCMs;

(iv) Requires States to develop a quality assessment and performance improvement strategy;

(v) Specifies certain prohibitions aimed at the prevention of fraud and abuse;

(vi) Provides that a State may not enter into contracts with MCOs unless it has established intermediate sanctions that it may impose on an MCO that fails to comply with specified requirements; and

(vii) Makes other minor changes in the Medicaid program.

(b) *Scope.* This part sets forth requirements, prohibitions, and procedures for the provision of Medicaid services through MCOs, PIHPs, PAHPs, and PCCMs. Requirements vary depending on the type of entity and on the authority under which the State contracts with the entity. Provisions that apply only when the contract is under a mandatory managed care program authorized by section 1932(a)(1)(A) of the Act are identified as such.

§438.2 Definitions.

As used in this part—

Capitation payment means a payment the State agency makes periodically to a contractor on behalf of each recipient enrolled under a contract for the provision of medical services under the State plan. The State agency makes the payment regardless of whether the particular recipient receives services during the period covered by the payment.

Comprehensive risk contract means a risk contract that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

(1) Outpatient hospital services.

(2) Rural health clinic services.

(3) FQHC services.

(4) Other laboratory and X-ray services.

(5) Nursing facility (NF) services.

(6) Early and periodic screening, diagnostic, and treatment (EPSDT) services.

(7) Family planning services.

(8) Physician services.

(9) Home health services.

Federally qualified HMO means an HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act.

Health care professional means a physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Health insuring organization (HIO) means a county operated entity, that in exchange for capitation payments, covers services for recipients—

(1) Through payments to, or arrangements with, providers;

(2) Under a comprehensive risk contract with the State; and

(3) Meets the following criteria—

(i) First became operational prior to January 1, 1986; or

(ii) Is described in section 9517(e)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by section 4734 of the Omnibus Budget Reconciliation Act of 1990).

Managed care organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is—

(1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or

(2) Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:

(i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity.

(ii) Meets the solvency standards of §438.116.

Nonrisk contract means a contract under which the contractor—

(1) Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in §447.362 of this chapter; and

(2) May be reimbursed by the State at the end of the contract period on the basis of the incurred costs, subject to the specified limits.

Prepaid ambulatory health plan (PAHP) means an entity that—

(1) Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;

(2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and

(3) Does not have a comprehensive risk contract.

Prepaid inpatient health plan (PIHP) means an entity that—

(1) Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;

(2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and

(3) Does not have a comprehensive risk contract.

Primary care means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary care case management means a system under which a PCCM contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid recipients.

Primary care case manager (PCCM) means a physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services or, at State option, any of the following:

(1) A physician assistant.

(2) A nurse practitioner.

(3) A certified nurse-midwife.

Risk contract means a contract under which the contractor—

(1) Assumes risk for the cost of the services covered under the contract; and

(2) Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

§438.6 Contract requirements.

(a) *Regional office review.* The CMS Regional Office must review and approve all MCO, PIHP, and PAHP contracts, including those risk and nonrisk contracts that, on the basis of their value, are not subject to the prior approval requirement in §438.806.

(b) *Entities eligible for comprehensive risk contracts.* A State agency may enter into a comprehensive risk contract only with the following:

(1) An MCO.

(2) The entities identified in section 1903(m)(2)(B)(i), (ii), and (iii) of the Act.

(3) Community, Migrant, and Appalachian Health Centers identified in section 1903(m)(2)(G) of the Act. Unless they qualify for a total exemption under section 1903(m)(2)(B) of the Act, these entities are subject to the regulations governing MCOs under this part.

(4) An HIO that arranges for services and became operational before January 1986.

(5) An HIO described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as added by section 4734(2) of the Omnibus Budget Reconciliation Act of 1990).

(c) *Payments under risk contracts*—(1) *Terminology.* As used in this paragraph, the following terms have the indicated meanings:

(i) *Actuarially sound capitation rates* means capitation rates that—

(A) Have been developed in accordance with generally accepted actuarial principles and practices;

(B) Are appropriate for the populations to be covered, and the services to be furnished under the contract; and

(C) Have been certified, as meeting the requirements of this paragraph (c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

(ii) *Adjustments to smooth data* means adjustments made, by cost-neutral methods, across rate cells, to compensate for distortions in costs, utilization, or the number of eligibles.

(iii) *Cost neutral* means that the mechanism used to smooth data, share risk, or adjust for risk will recognize both higher and lower expected costs and is not intended to create a net aggregate gain or loss across all payments.

(iv) *Incentive arrangement* means any payment mechanism under which a contractor may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract.

(v) *Risk corridor* means a risk sharing mechanism in which States and contractors share in both profits and losses under the contract outside of predetermined threshold amount, so that after an initial corridor in which the contractor is responsible for all losses or retains all profits, the State contributes a portion toward any additional losses, and receives a portion of any additional profits.

(2) *Basic requirements.* (i) All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound.

(ii) The contract must specify the payment rates and any risk-sharing mechanisms, and the actuarial basis for computation of those rates and mechanisms.

(3) *Requirements for actuarially sound rates.* In setting actuarially sound capitation rates, the State must apply the following elements, or explain why they are not applicable:

(i) Base utilization and cost data that are derived from the Medicaid population, or if not, are adjusted to make them comparable to the Medicaid population.

(ii) Adjustments made to smooth data and adjustments to account for factors such as medical trend inflation, incomplete data, MCO, PIHP, or PAHP administration (subject to the limits in paragraph (c)(4)(ii) of this section), and utilization;

(iii) Rate cells specific to the enrolled population, by—

(A) Eligibility category;

(B) Age;

(C) Gender;
(D) Locality/region; and
(E) Risk adjustments based on diagnosis or health status (if used).

(iv) Other payment mechanisms and utilization and cost assumptions that are appropriate for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims, using risk adjustment, risk sharing, or other appropriate cost-neutral methods.

(4) *Documentation.* The State must provide the following documentation:

(i) The actuarial certification of the capitation rates.

(ii) An assurance (in accordance with paragraph (c)(3) of this section) that all payment rates are—

(A) Based only upon services covered under the State plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration).

(B) Provided under the contract to Medicaid-eligible individuals.

(iii) The State's projection of expenditures under its previous year's contract (or under its FFS program if it did not have a contract in the previous year) compared to those projected under the proposed contract.

(iv) An explanation of any incentive arrangements, or stop-loss, reinsurance, or any other risk-sharing methodologies under the contract.

(5) *Special contract provisions.* (i) Contract provisions for reinsurance, stop-loss limits or other risk-sharing methodologies must be computed on an actuarially sound basis.

(ii) If risk corridor arrangements result in payments that exceed the approved capitation rates, these excess payments will not be considered actuarially sound to the extent that they result in total payments that exceed the amount Medicaid would have paid, on a fee-for-service basis, for the State plan services actually furnished to enrolled individuals, plus an amount for MCO, PIHP, or PAHP administrative costs directly related to the provision of these services.

(iii) Contracts with incentive arrangements may not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement, since such total payments will not be considered to be actuarially sound.

(iv) For all incentive arrangements, the contract must provide that the arrangement is—

(A) For a fixed period of time;
(B) Not to be renewed automatically;
(C) Made available to both public and private contractors;
(D) Not conditioned on intergovernmental transfer agreements; and
(E) Necessary for the specified activities and targets.

(v) If a State makes payments to providers for graduate medical education (GME) costs under an approved State plan, the State must adjust the actuarially sound capitation rates to account for the GME payments to be made on behalf of enrollees covered under the contract, not to exceed the aggregate amount that would have been paid under the approved State plan for FFS. States must first establish actuarially sound capitation rates prior to making adjustments for GME.

(d) *Enrollment discrimination prohibited.* Contracts with MCOs, PIHPs, PAHPs, and PCCMs must provide as follows:

(1) The MCO, PIHP, PAHP, or PCCM accepts individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by the Regional Administrator), up to the limits set under the contract.

(2) Enrollment is voluntary, except in the case of mandatory enrollment programs that meet the conditions set forth in § 438.50(a).

(3) The MCO, PIHP, PAHP, or PCCM will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll.

(4) The MCO, PIHP, PAHP, or PCCM will not discriminate against individuals eligible to enroll on the basis of race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

(e) *Services that may be covered.* An MCO, PIHP, or PAHP contract may cover, for enrollees, services that are in addition to those covered under the State plan, although the cost of these

services cannot be included when determining the payment rates under § 438.6(c).

(f) *Compliance with contracting rules.* All contracts under this subpart must:

(1) Comply with all applicable Federal and State laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act; and

(2) Meet all the requirements of this section.

(g) *Inspection and audit of financial records.* Risk contracts must provide that the State agency and the Department may inspect and audit any financial records of the entity or its subcontractors.

(h) *Physician incentive plans.* (1) MCO, PIHP, and PAHP contracts must provide for compliance with the requirements set forth in §§ 422.208 and 422.210 of this chapter.

(2) In applying the provisions of §§ 422.208 and 422.210 of this chapter, references to "M+C organization", "CMS", and "Medicare beneficiaries" must be read as references to "MCO, PIHP, or PAHP", "State agency" and "Medicaid recipients", respectively.

(i) *Advance directives.* (1) All MCO and PIHP contracts must provide for compliance with the requirements of § 422.128 of this chapter for maintaining written policies and procedures for advance directives.

(2) All PAHP contracts must provide for compliance with the requirements of § 422.128 of this chapter for maintaining written policies and procedures for advance directives if the PAHP includes, in its network, any of those providers listed in § 489.102(a) of this chapter.

(3) The MCO, PIHP, or PAHP subject to this requirement must provide adult enrollees with written information on advance directives policies, and include a description of applicable State law.

(4) The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

(j) *Special rules for certain HIOs.* Contracts with HIOs that began operating on or after January 1, 1986, and that the statute does not explicitly exempt from requirements in section 1903(m) of the Act, are subject to all the requirements of this part that apply to MCOs and contracts with MCOs. These HIOs may enter into comprehensive risk contracts only if they meet the criteria of paragraph (a) of this section.

(k) *Additional rules for contracts with PCCMs.* A PCCM contract must meet the following requirements:

(1) Provide for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions.

(2) Restrict enrollment to recipients who reside sufficiently near one of the manager's delivery sites to reach that site within a reasonable time using available and affordable modes of transportation.

(3) Provide for arrangements with, or referrals to, sufficient numbers of physicians and other practitioners to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care.

(4) Prohibit discrimination in enrollment, disenrollment, and re-enrollment, based on the recipient's health status or need for health care services.

(5) Provide that enrollees have the right to disenroll from their PCCM in accordance with § 438.56(c).

(l) *Subcontracts.* All subcontracts must fulfill the requirements of this part that are appropriate to the service or activity delegated under the subcontract.

(m) *Choice of health professional.* The contract must allow each enrollee to choose his or her health professional to the extent possible and appropriate.

§ 438.8 Provisions that apply to PIHPs and PAHPs.

(a) The following requirements and options apply to PIHPs, PIHP contracts, and States with respect to PIHPs, to the same extent that they apply to MCOs, MCO contracts, and States for MCOs.

(1) The contract requirements of § 438.6, except for requirements that pertain to HIOs.